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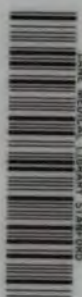
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S U R G E R Y ;

PATHOLOGICAL, DIAGNOSTIC, THERAPEUTIC,
AND OPERATIVE.

BY

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IN TWO VOLUMES.

VOL. II.



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HENRY O. LEA.

1877

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PART SECOND.

SPECIAL SURGERY;

OR,

DISEASES AND INJURIES

OF

PARTICULAR ORGANS, TEXTURES, AND REGIONS.

SYSTEM OF SURGERY.

SPECIAL SURGERY; OR DISEASES AND INJURIES OF PARTICULAR ORGANS, TEXTURES, AND REGIONS.

CHAPTER I.

DISEASES AND INJURIES OF THE JOINTS.

SECT. I.—DISLOCATIONS.

I. GENERAL CONSIDERATIONS.

A DISLOCATION, or luxation, is the sudden and forcible removal of one articular surface from another, either as an effect of external violence, of inordinate muscular contraction, or of a diseased condition of the component structures of the affected joint.

As all joints are necessarily composed of at least two bones, the question naturally arises, which should be considered as the luxated one? Upon this subject all surgical authorities are, I believe, agreed. In every accident of this description the bone nearest the trunk is regarded as the fixed bone, and the one articulated with it as the dislocated. Thus, in luxation of the shoulder-joint, the scapula retains its normal position, either actually or supposititiously, while the humerus is thrown off the glenoid cavity, at one time in this direction, and at another in that. In dislocation of the elbow, the ulna and radius are forced away from the humerus, the latter serving as the fixed point. The same rule obtains in regard to all the articulations of the inferior extremity.

Dislocations are divisible into simple and complicated, complete and incomplete, primitive and consecutive, recent and old, single and double. When the accident occurs before birth it is designated by the term congenital.

A luxation is said to be simple when it is unaccompanied by anything more than a slight rupture of the ligaments, or of the ligaments and muscles. Although such an accident is usually produced by external force, as a blow or fall, it may occasionally arise purely from muscular action, especially when it is favored by disease of the affected joint.

In a complicated dislocation there is, in addition to the loss of relation between the two contiguous surfaces, some serious lesion of the soft parts, as, for example, a wound communicating with the displaced bone or opening directly into the articulation, laceration of important vessels or nerves, contusion of the skin and muscles, or fracture of the luxated bone. When the wound penetrates the affected joint, the accident is usually called a compound dislocation.

A complete luxation is one in which the head of a bone, totally removed from its corresponding articular surface, effects a lodgment in a new situation, as, for instance, when the head of the humerus is forced down into the axilla, resting against the border of the scapula, below the glenoid cavity. In an incomplete luxation, on the contrary, the articular surfaces, although they have lost their relative position, remain still partially in contact with each other.

In primitive dislocation, the displaced bone remains in the position into which it was originally forced; in consecutive, it abandons its first situation, and is fixed in another. Such an accident, however, can only happen, as a general rule, when the

luxation depends upon some organic disease of the articular surfaces, allowing them gradually to separate from each other, either by the mere weight of the corresponding limb, or by the action of the neighboring and associated muscles. In the traumatic form of the injury such an event must be exceedingly rare, although we must admit its possibility, the dislocating agent forcing the bone at once to the greatest verge of its displacement; or, as not unfrequently occurs, its further progress is effectually arrested by some opposing osseous prominence or some tensely strung soft part, as a tendon, muscle, or fibrous membrane. Luxation of the knee-joint from caries of the articular surfaces furnishes a characteristic exemplification of these two kinds of displacement. In this accident the head of the tibia gradually forsakes the condyles of the femur, slipping back into the popliteal region, whence, in time, it is drawn up against the posterior surface of the bone by the flexor muscles, thus suffering secondary luxation. A similar occurrence, although exceedingly uncommon, may, nevertheless, happen in a very robust subject in traumatic dislocation of the hip, shoulder, or lower jaw, where the force is barely sufficient to lift the head of the bone out of its socket upon, but not over, its rim, from which it is afterwards removed either by mere muscular contraction, or by the conjoint influence of this and the weight of the part connected with the displaced bone.

The terms recent and old refer merely to the duration of the injury, and might seem, at first view, to require no particular explanation. The propriety of this, however, will be rendered at once obvious if the question be asked, when does a dislocation become old? does it become old in a few days, or weeks, or months? So far as mere time is concerned, no lesion of this kind can be regarded as old unless it has existed for at least from six to twelve months; but if we look at the subject in reference to the ability of the surgeon to restore the affected joint to its natural relations, it will be found that, while one dislocation may not be old at the end of several months, another may become so within the first few weeks. Thus, a luxated shoulder may frequently be successfully reduced after a lapse of two months, or even considerably later, whereas if an attempt be made to restore a dislocated elbow at the end of one-third or even one-fourth of that time, signal failure will generally follow. The import of these two terms, then, is one of much greater importance than has commonly been admitted, having, practically considered, a positive value and significance.

A single dislocation is one in which only one joint is involved; in the double form of the accident, on the contrary, the corresponding joint is likewise affected. The lower jaw suffers more frequently in the latter way than any other bone, but a similar displacement is also occasionally witnessed in the humerus, ulna, radius, clavicle, ilium, and fibula. Double luxations may be complete or incomplete, simple or complicated.

Joints which admit of varied and extensive motion are much more prone to this injury than such as enjoy only a very limited motion. Hence, what are called the ball and socket joints, of which those of the hip and shoulder are the best representatives, suffer much oftener than the ginglymoid, as those of the elbow and knee. The tables of Malgaigne prove that dislocations of the shoulder are more frequent than those of all the other movable articulations together, 321 cases out of 481 having occurred here. Comparing the relative proportion of cases in the two extremities, the same distinguished observer finds that they are seven times more numerous in the superior than in the inferior. These differences in the relative frequency of the lesion in different joints are, as already stated, clearly referable to the differences in their structure and functions. Of all the large articulations, that of the shoulder is the most insecurely constructed; the glenoid cavity is remarkably shallow; the capsular ligament is long and loose, and the joint, admitting of every variety of motion, is under the direct influence of numerous powerful muscles, and exposed to numerous accidents. Why, then, should it be surprising that it is so often the seat of dislocation? The hip-joint, on the contrary, is the most admirably contrived joint of which it is possible to form any conception; as a piece of mechanism it is perfect; the acetabulum is an immense socket, in which the whole head of the femur is literally buried, and to which it is still further secured by two powerful ligaments, the round and the capsular; and, in addition to all this, it is surrounded by numerous large muscles, which serve to support and protect it from injury. Thus constituted, this articulation is comparatively seldom the seat of dislocation, hardly, as compared with that of the shoulder-joint, in the proportion of 1 to 9 $\frac{1}{2}$. The clavicle,

which enjoys only a very limited degree of motion, is not unfrequently luxated, its exposed situation and its buttress-like office rendering it peculiarly prone to the accident, occupying, in this respect, nearly the same rank, according to Malgaigne's statistics, as the hip-joint.

Thus, recapitulating what has been said above, it may be concluded that the most powerful predisposing causes of dislocation are, varied and extensive motion of the joints, want of firmness between the articulating surfaces, arising either from their shallowness or the structure and arrangement of their ligaments, and the exposed situation and peculiar functions of the bones entering into their composition.

The direction in which dislocations occur is subject to much diversity, depending upon the nature of the joint, and the direction in which the force is applied at the time of the accident. In the ginglymoid articulations the bones may be displaced backwards, forwards, or to either side; in the orbicular, as, for example, that of the shoulder, downwards, forwards, upwards, or backwards.

Although dislocations occur at all periods of life, they are by far most common in middle-aged and elderly persons. Of 643 cases, analyzed by Malgaigne, only one was noticed before the fifth year, and none after the ninetieth. The greatest number took place between the thirtieth and sixty-fifth years. The reason of these differences is to be found in the circumstance that the bones of young subjects, being comparatively soft and pliant, and not yet everywhere completely solidified, yield most easily at their epiphyses and even at their shafts, while those of very old and decrepit persons are generally so brittle that it requires much less force to break than to luxate them. It is seldom that an opportunity is afforded of seeing a dislocation of the hip-joint after the age of sixty, while it is very common to meet with fracture of the neck of the femur within the capsular ligament. This statement, however, must be received with some degree of restriction, for it is obviously not applicable to all the articulations. The shoulder-joint, for instance, forms a striking exception, its dislocation in old age being much more frequent than fracture of the superior extremity of the humerus.

Causes.—The efficient causes of dislocation are external injury and muscular contraction. Most cases are due to the former, acting either directly upon the joint, or indirectly through some bone articulated with it. Dislocation of the shoulder, consequent upon a blow or fall upon its summit, affords a good illustration of the manner in which injury acts when applied directly to an articulation. In this case the force is spent upon the superior extremity of the humerus, propelling the head of the bone down into the axilla, beyond the glenoid cavity of the scapula. The femur may be luxated in a similar manner, by a heavy body falling on the hip, while the thigh is in a state of abduction. Lateral dislocation of the patella is another instance of displacement occasioned by direct violence. Sometimes a severe wrench is necessary to produce the accident, especially when the bones are connected by short and strong ligaments, requiring great force to separate them.

A more common mode of causing this accident is by the indirect application of force. Indeed, nearly all the dislocations of the upper extremity, and many also of the lower, are the result of violence, transmitted from the distal portion of the limb, and concentrated upon some particular bone, which thus loses its connection with the opposing surface. It is in this manner that falls upon the hand so often luxate the elbow, and even the shoulder, according to the point upon which the violence is exploded. Dislocation of the clavicle is usually induced by falls upon the shoulder, in which this bone is acted upon by two forces coming in opposite directions, the one being caused by the weight of the body, and the other by the object struck.

Of the ability of the muscles to induce this accident, experience has furnished ample proof. I have myself witnessed a number of examples of it, mostly in the shoulder, during attacks of epilepsy. In one, the accident occurred simply by raising the hand above the level of the head. Yawning is a common cause of dislocation of the lower jaw. Several cases have been recorded of displacement of the thigh-bone by muscular contraction. In the ginglymoid joints such occurrences must, for obvious reasons, be much less frequent than in the orbicular.

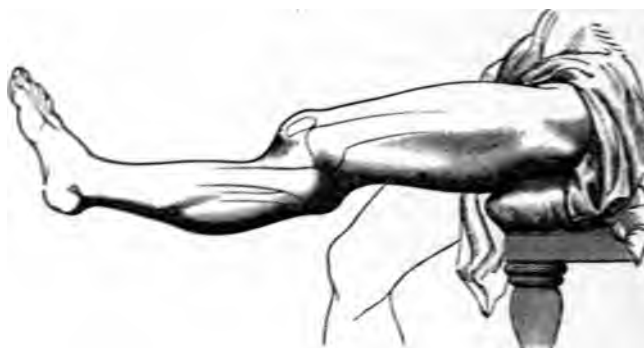
Some persons possess the power of dislocating certain joints voluntarily, simply by muscular action. I have met with several individuals who possessed this faculty, but I have always noticed that, however strongly they exerted themselves, they

could not produce anything like a complete displacement of the articular surfaces, and it is presumable that most of the examples that have been reported have been of this description. Dr. Haynes, of Saranac, New York, has published the particulars of the case of a lad, seven years old, who is said to be able to luxate, and also to reduce, the joints of the knee, elbow, wrist, thumb, and fingers, with perfect ease, by muscular contraction.

In all cases of dislocation, whether the result of direct or indirect injury or of muscular contraction, the accident is materially favored by a partial separation of the articular surfaces. The lower jaw cannot suffer displacement so long as it is closed, but if the chin be struck while the body is depressed, and the condyle drawn forward upon the anterior convex part of the temporal fossa, the slightest blow will suffice to throw the bone down over the root of the zygomatic process. Dislocation of the humerus into the axilla is greatly promoted by abduction and elevation of the arm. The femur is generally luxated upwards and backwards against the dorsal surface of the ilium, by falls upon the hip, and the occurrence is always greatly facilitated by the circumstance of the patient having a heavy load on the back. A twisted or contorted state of the limb is generally highly conducive to the accident.

Organic disease of a joint may become a cause of dislocation, as seen in fig. 1, from a patient of Professor T. G. Richardson. The man had labored for a long

Fig. 1.



Dislocation of the Knee from Disease.

time under an arthritic affection of the knee, which was gradually followed by permanent displacement of the head of the tibia backwards behind the condyles of the femur. There was no external disease of any kind. The head of the bone could easily be reduced, but not kept in position, owing, apparently, to the complete destruction of the ligaments of the joint.

2. SIMPLE DISLOCATIONS.

Dislocations are characterized by a certain train of symptoms, by which they may generally be easily distinguished from other accidents. Of these symptoms, the most constant and prominent are, loss of function of the affected articulation, lodgment of the displaced bone in an unnatural situation, deformity of the joint, and change in the mobility, length, and axis of the corresponding limb. To these may be added, as subordinate phenomena, the noise which is occasionally heard by the patient at the moment of the accident, numbness of the parts from pressure of the luxated bone upon the nerves, contusion and discoloration of the integument, together with pain, swelling, and crepitation as effects of the resulting inflammation.

Immediate and, generally, entire loss of function of the affected joint is a necessary consequence of dislocation, however induced. Thus, in luxation of the temporo-maxillary articulation, the lower jaw is widely separated from the upper, and cannot be closed by any effort that the patient may make. When the principal joints of the upper extremity are affected, the person is unable, without assistance, to carry his hand to the head, or to execute the motions of flexion, extension, circumduction, pronation, and supination; the whole limb feels heavy and numb, and requires to be

supported by the sound one. In dislocation of the foot, leg, and thigh, progression is not only impracticable, but every attempt of the kind is attended with so much distress as to cause its immediate discontinuance. The loss of function necessarily persists so long as the joint remains unreduced, although, eventually, it is often partially regained.

Impairment of the motion of the corresponding limb is an important symptom. The patient, in general, not only loses all voluntary control over the member, but the surgeon, upon taking hold of it, and attempting to carry it about in different directions, finds it impossible to effect his object. Motion, it is true, is not always completely abolished, but there is no case in which it is not considerably, if, indeed, not greatly, restricted. In some of the articulations, as, for example, in that of the elbow, the displaced bones are so thoroughly interlocked as to render it difficult, even by the most adroit and persevering efforts at extension and counter-extension, to disengage them from each other, and restore them to their natural situation. Immobility, therefore, is one of the most valuable symptoms of dislocation. Its causes are threefold, muscular contraction, opposing osseous prominences, and constricting ligamentous bands, or all these united. A knowledge of these obstacles is of great practical moment, as it involves important therapeutic considerations, which cannot be too well understood.

In most cases the surgeon is able to feel the displaced bone in its new situation, beyond the limits of the corresponding articular surface. Sometimes, indeed, it may even be readily detected with the eye, by the prominence which it forms by raising up the muscles and integument. In order to ascertain the precise position of the bone, a careful examination will generally be required, especially when there is much tumefaction obscuring the symptoms. For this purpose one hand is placed upon the injured joint, while the other is employed in moving the corresponding limb; when greater accuracy is necessary, this office is confided to an assistant, in order that both hands may be used for conducting the investigation. If the manipulation is productive of severe pain, it should be desisted from until the system has been brought fully under the influence of anæsthesia. The distance to which the head of the displaced bone is thrown varies, in different cases, from a few lines to several inches, depending upon the size and shape of the joint, and the amount of force employed in producing the accident; as a general rule, it is greater in the orbicular than in the ginglymoid articulations.

Deformity of the joint is commonly one of the most reliable symptoms. It usually manifests itself in a marked flattening of the articulation, as in dislocation of the humerus into the axilla, in which there is always a loss of rotundity of the cushion of the shoulder from the manner in which the deltoid muscle is spread out; or, in great increase of the width of the joint, as in lateral luxation of the elbow and knee. Sometimes the joint has a singularly contorted, angular, or twisted appearance.

A marked change in the length of the limb articulated with the displaced bone is generally present. It is seldom that the limb retains entirely its normal length; most commonly this is either increased or diminished, the extent varying according to the structure of the joint and the degree of force employed to produce the accident. Shortening is much more frequent than elongation. Thus, in the various forms of luxation of the shoulder and hip there is only one in each in which the limb is increased in length, while in all the rest it is considerably, if not greatly, shortened, amounting in some of them to several inches. No material difference exists in regard to this symptom in the dislocations of the orbicular and the ginglymoid articulations.

Dislocation changes not only the length of the affected limb, but also, in most cases, its axis, giving it a peculiarly contorted or twisted appearance. This appearance is nowhere more conspicuous than in the displacements of the elbow-joint, in some of which it is almost diagnostic. Another excellent illustration of this occurrence is afforded in luxation of the head of the humerus into the axilla, where this trait is often so well marked as at once to convince the practised eye of the nature of the accident. In most of the displacements of the orbicular joints the limb stands off at a considerable distance from the body, in a constrained and twisted state.

Of the subordinate symptoms there is not one that is of any actual value; nevertheless, they are deserving of some consideration, if for no other reason than that of completing the history of this accident.

It is highly probable that most dislocations, at least those of the larger joints, are attended with some degree of noise at the moment of their occurrence; but that this noise is not often heard by the patient may be assumed from the fact that he is so seldom conscious of it, owing to the confused state of mind into which he is thrown by the sudden and unexpected nature of the accident. Its character cannot be easily described, but it may, perhaps, be said to bear a closer resemblance to a crackling sound than any other to which it can be compared. It is, apparently, caused by the sudden and forcible separation of the articular surfaces, and is generally most distinct in luxations of the orbicular joints.

A considerable degree of numbness is occasionally felt in the parts immediately around the affected joint, and even in the whole of the corresponding limb. It evidently depends upon the compression of the nerves by the displaced bone, and is particularly distressing in axillary dislocations of the shoulder, in which the tingling sensation often extends to the very tips of the fingers.

More or less contusion and discoloration are often present. The contusion may be accompanied by scratches of the skin, or even by considerable wounds, thus complicating the case. The discoloration varies from the slightest change of the normal hue to deep purple, depending upon the size and number of the injured vessels. Large quantities of blood are sometimes effused among the tissues in the immediate vicinity of the affected joint and even into the joint itself.

The pain consequent upon dislocations varies greatly in different individuals, often depending, perhaps, quite as much upon their idiosyncrasy as upon the severity of the injury. Its immediate cause, of course, is the rupture of the ligaments and other structures in and around the affected joint, and may, on the one hand, be so excessive as to induce fainting and other distressing effects, or, on the other, so insignificant as hardly to attract attention. It is always increased by manipulation and motion, as well as by the resulting inflammation, and may continue for days and weeks. In nervous, irritable subjects it occasionally assumes a neuralgic character. When the displaced bone compresses an important nerve, the pain is generally attended with a feeling of numbness and tingling.

More or less swelling always succeeds to dislocations; sometimes almost instantly, but generally not under several hours; at one time slight, at another exceedingly severe. When it appears suddenly, within a few minutes after the accident, it is always due to effusion of blood, and is then either attended or soon followed by discoloration of the integument. Coming on more slowly, it may reasonably be concluded to be the result purely of inflammatory deposits, especially of serum and lymph, or of these deposits and of blood combined. When the incited action runs very high, the swelling is generally proportionately great, the part being hard, stiff, glossy, painful, and intolerant of manipulation.

The friction-sound which occasionally attends recent unreduced dislocations has been ascribed to different causes; by some, as J. L. Petit, to dryness of the articular cartilages; by others, to the presence of a superabundance of synovial fluid; by Sir Astley Cooper, to a deposit of fibrin in the joint and the neighboring bursae; by Malgaigne, to the rubbing of the head of the luxated bone against an osseous surface denuded of its periosteum. I am strongly inclined to the belief of the English surgeon that it is mainly, if not wholly, due to plastic effusion into and around the articulation, an idea strengthened by the fact that it can never be elicited until after the occurrence of inflammation. If it were occasioned by dryness of the articular cartilages, or denudation of the bone, it ought, as a natural consequence, to be perceptible immediately after the infliction of the injury.

The term friction perhaps expresses the nature of this sound better than any other that can be employed; it is entirely different from the grating noise and sensation caused by rubbing together the two ends of a broken bone; it is more like the sound occasioned by rubbing over each other two pieces of sole-leather; it is a soft, creaking, or crackling noise, not a grating one.

Diagnosis.—The accident with which dislocation is most liable to be confounded is undoubtedly fracture, especially fracture in the vicinity of the articulations, an occurrence not only quite frequent, but generally exceedingly embarrassing, on account of the difficulty of its diagnosis. The most constant and reliable symptoms of dislocation, as already stated, are, deformity, both of the affected joint and limb, loss of function, impaired motion, and difficulty of restoring the displaced bone to

its natural situation. In fracture the most important characters are, distortion, preternatural mobility, and crepitation, with facility of reduction.

If these symptoms be compared with each other, it will be found that, although there is some resemblance between some of them, yet that, in the main, they are strikingly dissimilar, and, therefore, in so far, diagnostic of the accidents which they respectively serve to characterize. Deformity is common to both dislocation and fracture, and, for this reason, is of little, if any, value as a point of distinction between them. The same is true of the loss of function, which is often, perhaps generally, quite as great in the one as in the other. If a man with a luxated hip may occasionally support the weight of his body upon the affected limb, or even walk slightly upon it, he can sometimes do as much, and even more, when he has an impacted fracture of the femur, or a fracture of the neck of that bone temporarily unattended with a separation of the fragments. A dislocated jaw is quite as helpless as a broken one; in neither case can it perform the office of mastication. Both these symptoms, then, are without the slightest diagnostic value. But it is very different with the others above enumerated. Mobility, for example, is a differential sign of great significance. In dislocation, mobility is either entirely lost, or very much impaired; the displaced bone is more or less firmly fixed in its new situation, and can only be restored to its natural position by more or less powerful efforts, often long and anxiously continued. In fracture, on the contrary, there is always an increase of motion, or, more properly speaking, there is preternatural mobility, the limb allowing itself to be bent, extended, and even rotated upon its axis. Moreover, by extension and counter-extension the member may readily be restored to its natural length and shape, but the moment these efforts are discontinued there is a reproduction of all the previous symptoms. Such an event never happens in dislocation; when the bone is once reduced it remains reduced, unless accident should again lift it out of its socket. Lastly, in luxation the replacement is usually attended with a peculiar noise or snap, caused by the forcible contact of the opposing surfaces; in fracture no such noise is ever distinguishable. Crepitation is another valuable diagnostic in these accidents. In dislocation the only sound ever perceived is a kind of friction-sound, and even this is never present until after the supervention of inflammation; in fracture, on the contrary, crepitation is one of the most important symptoms; indeed, it is the characteristic sign of the lesion. It may be detected immediately after the accident, and during all stages of the after-treatment up to the time of incipient union. Deformity and preternatural mobility may both be absent, and yet if there be crepitation, or a rough grating noise and feel upon rubbing together the ends of the broken bone, there can be no doubt respecting the real nature of the case. It is a fracture, and nothing else. So, on the other hand, if there be deformity and loss of motion, with absence of crepitation, the rational inference is that the case is one of luxation, or, at all events, not of fracture.

Another valuable sign, but one which has only a general application, is the difference in the position of the affected limbs in the two classes of injuries. In dislocation the limbs often stand off at a considerable distance from the body, in a constrained and unseemly attitude; in fracture, on the contrary, they always hang close by the side of the body. Most of the displacements of the hip and shoulder joints exhibit this peculiarity, and I consider it as of no little value as a means of discriminating between these lesions and fractures of the superior extremities of the femur and humerus.

Contusion, discoloration, pain, and swelling being common to both dislocation and fracture, are worthless in a diagnostic point of view. Instead of being of advantage in this respect, they generally only serve to embarrass the attempts at discrimination. Numbness, however, possesses a certain value, especially in some of the luxations of the shoulder and hip, where it occasionally constitutes a prominent and distressing symptom, which is never the case in fracture, except under very rare circumstances, when the ends of the broken bone pierce, bruise or compress a large nerve.

Important aid may sometimes be derived from a knowledge of the position which the dislocated bone is most liable to occupy. Thus, in displacement of the shoulder, the head of the humerus is usually thrown into the axilla, or forwards against the chest, seldom upwards or backwards; the most common luxations of the femur are those upon the dorsal surface of the ilium and into the sciatic notch. In the

ginglymoid joints, especially those of the knee and elbow, posterior displacement is most common.

After all, however, no matter what may be the character or prominence of the symptoms, a correct and reliable diagnosis can only be attained by a thorough examination of the condition of the parts concerned. Without the light which such an investigation is capable of furnishing, no surgeon, however skilful or experienced, can always be certain whether the accident is really a dislocation or a fracture, or whether these lesions do not coexist. In conducting the examination, the same general rules are applicable as in fracture. The sooner, of course, it is made, the less likely will it be to occasion severe suffering to the patient, or annoying embarrassment to the practitioner. When the parts have become tumid and infiltrated, the nature of the accident is usually very much obscured, and the manipulation only aggravates the already existing mischief. Besides, they will then be so painful as to render it impossible to touch them unless the patient is under the influence of an anæsthetic. It is unnecessary to say that when a joint is in this condition, it must be handled with the greatest care and gentleness; yet, at the same time, the exploration should be thorough, otherwise it cannot be satisfactory, and if one trial is not sufficient, another should be made soon after the first, means being used, meanwhile, to allay pain and inflammation, in order to render the parts more tolerant of manipulation.

A careful measurement of the affected limb, or, rather, of the portion of the limb between the affected joint and the one next below, often throws valuable light upon the diagnosis. Thus, if, in injury of the shoulder-joint, the distance between the acromion process and the elbow is found to be considerably greater than on the sound side, it will be a legitimate inference that the case is one of dislocation into the axilla, and not of fracture of the head or neck of the humerus. In luxation of the elbow backwards, the forearm is always sensibly shortened, only, however, in front, for behind it must necessarily retain its normal length. The measurement must be taken with a piece of tape, which, in order to insure greater accuracy, should, if possible, be graduated, the ends being applied against two fixed points, and the same operation being performed upon the sound limb.

When, notwithstanding all these examinations and precautions, the case remains doubtful, it will be well to adopt the suggestion of Malgaigne of inserting a long, slender needle into the joint, and also, if necessary, into the parts immediately around, with a view of ascertaining their precise condition. Should a hollow be found where there is naturally a projection, or a projection where there ought merely to be a cavity, the presumption will be strong that the case is one of dislocation, and the conjecture will be converted into positive certainty if there be absence of crepitation and preternatural mobility. There can be no possible objection to such an exploration, if due attention be paid to the larger vessels and nerves, and if the instrument be sufficiently slender to make only a small puncture, and so well tempered as not to break. It is surprising, when we consider the facility and safety of this operation, and the undoubted light which it is capable of affording in obscure cases of this accident, that it has not attracted more attention, or been more frequently employed.

Finally, dislocations are sometimes painfully simulated by sprains, so much so, indeed, as to puzzle and perplex the most sagacious observer. In such an event, nothing short of the most patient and accurate examinations and measurements, repeated again and again, both in the recumbent and in the erect posture, will be likely to prevent mistake.

Morbid Anatomy.—On dissecting a joint that has been recently luxated, the head of the bone will be found to be more or less removed from its socket, the distance to which it has been thrown ranging from a few lines to several inches, according to the structure of the parts involved, and the degree of force concerned in producing the accident. In the incomplete form of the lesion the articular surfaces still partially retain their apposition, while in the complete all connection is lost. The displaced head rests either upon some muscle, tendon, or bone, or upon all these structures, and the socket is generally occupied with blood, either fluid, or partly fluid and partly coagulated. The ligaments are lacerated, elongated, and relaxed, the extent of the rent varying from a mere fissure, barely large enough to admit the escape of the bone, to almost complete separation from their osseous attachments. The capsular ligaments are usually more extensively torn than the band-like, and, in

both cases, shreds of the injured structure are occasionally interposed between the bone and the parts upon which it rests. In dislocations from muscular contraction, as in those of the jaw and shoulder, slight laceration of the ligaments is generally conjoined with marked elongation, and dissection has rendered it probable that cases of this kind occasionally occur even without any rupture whatever. The muscles in the immediate vicinity of the injured articulation usually participate, at least to some extent, in the mischief sustained by the ligaments, being, like them, more or less stretched, contused, or even torn, although the latter occurrence is neither frequent nor extensive. The nervous trunks around the joint may be compressed and displaced by the luxated bone, but are rarely, if ever, lacerated, or seriously hurt in any way. The same is true of the larger vessels, both arterial and venous, the hemorrhage which follows the accident, and which is usually quite insignificant, proceeding from the smaller ligamentous, cellular, and muscular branches. If the patient has survived the accident several days, so that the parts have had time to become inflamed, more or less plastic matter will be found, both in the socket and in the neighboring tissues, matting and gluing them together.

Prognosis.—The prognosis of simple dislocations must be considered with reference to two circumstances, the restoration of the displaced bone, and the severity of the injury sustained by the accident. If attended to early, they may commonly be easily reduced, and are seldom dangerous either to life or limb. If, however, they are neglected, or improperly managed, more or less deformity and loss of motion must ensue, and the resulting inflammation may be so great as to cause serious constitutional disorder. Luxations of the orbicular joints are generally less hazardous than those of the ginglymoid, but they are nearly always more difficult of reduction, on account of the adjacent muscles being more numerous and powerful, and, consequently, more resisting. On the other hand, however, the displacements of the orbicular articulations retain their reducibility much longer than the ginglymoid; thus, a luxated shoulder may often be restored at the end of several months, whereas a luxated elbow generally becomes irreducible within as many weeks. In children, old persons, and females, the restoration is generally more easily accomplished than in adults, or in strong, robust individuals, whose muscles are more developed, and, therefore, less easily subdued. This difference obtains, in the same relative degree, even when anæsthetics are used.

Treatment.—The leading indications in the treatment of simple luxations are, first, to restore the articular surfaces as soon as possible to their natural situation; secondly, to keep the affected joint at rest until the lacerated ligaments and other structures have become repaired; thirdly, to limit and subdue inflammation; and, fourthly, to reëstablish the functions of the parts. The character of these indications, and the mode of fulfilling them, should be kept clearly and prominently before the eye of the practitioner; for, unless he has accurate and definite conceptions upon the subject, he must often fail in accomplishing his object in a satisfactory and creditable manner.

In entering upon the consideration of the treatment of this class of accidents, the first question that arises is, what are the causes which oppose their reduction, or, in other words, why is it that dislocations do not disappear of their own accord? Until recently it was generally supposed that the principal barrier to the reduction was the resistance offered by the muscles connected with the displaced bone, contracting at first spasmodically, and then permanently, so as to hold the part firmly in its new position. To overcome this action of the muscles in the vicinity of the affected joint has, therefore, always been a leading indication in the attempts at reduction; and yet how signally these attempts frequently fail, after the most thorough relaxation, not only of these muscles, but of the whole system, by the lancet, tartar emetic, and the warm bath, is well known. This fact of itself, then, is sufficient to prove that, although muscular contraction is one of the main agents which oppose the reduction, it is not by any means the only, nor always even the principal, one. If the difficulty depended merely upon the resistance of the muscles, whether spasmodically acting or temporarily shortened, the use of depressants and anæsthetics, aided by steady, persevering extension and counter-extension, ought to enable the surgeon to reduce, promptly and effectually, every dislocation whatever. But this is not the case; the patient, in former days, used to be bled to syncope, nauseated to the utmost with tartar emetic, and literally parboiled, and yet, half dead as he was, restoration was frequently impossible, and so it is still in these days of chloroform and ether.

This, then, being the fact, other opponents, capable at least of aiding the muscles in their resistance, or of themselves sufficient to offer a serious, if not insuperable, barrier to the reduction, must be sought for. Such obstacles are found in the bones and ligaments, and but for these it would be difficult to conceive of any case of dislocation that could resist, more than a few minutes, any well-directed efforts at restoration. In truth, almost every dislocation would reduce itself. Why is it that the surgeon frequently experiences so much trouble in replacing a luxated thumb? Is it not because of the resistance offered by the prominences and ligaments of the affected joint? The muscles of the thumb can certainly not, as active agents, exert any serious influence in preventing the reduction; for cases have occurred where the luxated phalanx was literally torn away in unsuccessful attempts of this kind. In dislocation of the jaw, the principal obstacle to the reduction is the zygomatic process of the temporal bone; and, although the temporal, pterygoid, and other muscles usually contract with great power, yet this would rather tend to favor the reduction than to prevent it if the condyle of the bone were not firmly locked in the fossa below. The obstacle which bony prominences offer to replacement is well shown in the luxations of the shoulder and hip, the former being always comparatively easy of reduction, on account of the smooth and shallow state of the margin of the glenoid cavity, while the latter, in consequence of the opposite state of the rim of the acetabulum, are generally comparatively difficult. This resistance, however, is always, other things being equal, most striking in the ginglymoid articulations, owing to the greater complexity of their structure, and their larger size, but more especially to the greater number and bulk of the neighboring prominences and depressions, thus permitting the displaced bone to become more readily interlocked with the fixed one.

A serious barrier to reduction is often afforded by the ligaments, caused by the small size or the peculiar shape of the rent made at the time of the accident, the bone passing readily through it, but being unable to return on account of the manner in which it is girt by the edges of the aperture; the membrane or cord being drawn over its neck like a purse with its string tightened. That this frequently happens in the capsular ligaments, in luxations of the orbicular joints, may readily be imagined when we take into consideration the difficulty of effecting reduction, however thoroughly the system may be relaxed, while, in regard to the funicular ligaments, or those of the ginglymoid articulations, the fact is abundantly attested by daily experience.

Finally, it is extremely probable that the reduction of certain dislocations is materially impeded, if not at times prevented, by the head of the displaced bone becoming entangled among the neighboring muscles or tendons, producing an effect similar to that occasioned by the ligaments and bones.

The means which are usually employed for surmounting these several obstacles consist of certain manipulations or manœuvres, as extension and counter-extension, conjoined, if necessary, with pressure and thorough relaxation of the system.

Occasionally mere pressure, if properly directed, is sufficient to effect reduction, especially when the dislocation is seated in a joint with loose ligaments, or when the ligaments are extensively lacerated and the neighboring muscles are in a passive, crippled, or paralyzed condition. In general, however, more or less extension and counter-extension will be required, and the mode of applying and conducting these becomes, therefore, a matter of paramount consequence. Upon these subjects much diversity of sentiment has existed among writers, some contending for one mode of practice, and others for another, as if it were possible to lay down any specific rules upon points of treatment which must necessarily vary according to the exigencies of each particular case. My own experience is that it is generally best to apply the extending power to the bone which is articulated with the luxated one, or, in other words, as far as possible from the site of injury. Many highly respectable authorities, however, select the distal portion of the displaced bone, under the supposition that it affords a more direct and influential leverage. In not a few instances, indeed, we are obliged to adopt this course from necessity, the nature of the case not admitting of any choice; as, for example, in dislocations of the wrist and elbow, and in the corresponding ones of the inferior extremity.

Extension and counter-extension may be made by the hands of intelligent assistants, aided, if requisite, by lacs, napkins, sheets, or pulleys. As a general rule, the resisting power, or the counter-extending means, should be fully equal to the

extending, and both should be applied in such a manner as to create as little inconvenience and pain as possible; they should be exerted slowly and gradually, and at the same time continuously, the object being not to fret the muscles which oppose the reduction, but to fatigue and exhaust them. Hence any sudden and violent movements would only be followed by mischief. With regard to the extension, it should always be first made in the direction of the luxated bone, but in proportion as the resistance is overcome the limb should gradually be brought back to its natural position.

During the reduction the patient may sit or lie, as may be most convenient, or as the exigencies of the case may seem to demand. Whenever chloroform is administered, recumbency is indispensable. The patient, as a general rule, should lie upon a bed or table during the reduction of nearly all the dislocations of the principal articulations, especially those of the shoulder, hip, and knee; in those of the elbow, hand, ankle, clavicle, and jaw, on the contrary, the sitting posture will be found most convenient for the surgeon. The number of assistants must vary from one to three, four, or five, according to the nature of the case, and it will be of great benefit if their duties are always accurately defined before the operation is entered upon, otherwise delay, annoyance, and embarrassment will be sure to arise. The counter-extending band, which generally consists of a folded sheet, a jack-towel, or, what is better, a long, stout piece of muslin, is fastened around the trunk or limb so as to diffuse its pressure over a considerable space, without the risk of injuring the soft parts, exciting the muscles in the neighborhood of the dislocation, or interfering mechanically with the return of the luxated bone. The extending band must also be secured with great care. The best plan is to envelop the surface of the limb to which it is to be applied with a soft, wet napkin, folded, and passed around at least twice. This answers the double purpose of protecting the skin and of preventing the noose or lac from slipping, which seldom fails to happen if a dry cloth be used. The lac should be of sufficient strength not to break, and should be fastened around the napkin by means of the clove-hitch or sailor's knot, the proper method of making which will readily be understood by a reference to the accompanying

Fig. 2.



Clove-hitch Knot.

Fig. 4.



Compound Pulleys.

Fig. 3.



Clove-hitch Knot applied.

sketches, fig. 2 and fig. 3. Or, instead of this, we may use the French knot, which is equally efficient, and which is executed by placing the band across the limb so as to form a loop on each side, each end being then passed under the limb through the opposite loop. In the more simple forms of dislocation, the requisite extension and counter-extension may be made with the hands, or by the pressure of the heel, knee, or fist.

Pulleys, fig. 4, are rarely required in the present improved mode of reducing dislocations, the use of anæsthetics and the "manual method," as it is termed, having well-nigh rendered their application unnecessary in all recent cases of the accident. I have myself not had occasion to employ them for many years, and there is reason

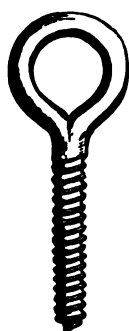
Fig. 5.



Pulleys applied.

to believe that, as we become better acquainted with the nature of the subject, they will ultimately be almost entirely dispensed with. There is no doubt that they have done immense mischief, even in the hands of otherwise judicious surgeons, and that they more frequently impede than favor reduction. A formal description of this instrument will be unnecessary here, as its appearance and office, known to every one, will easily be understood from the annexed representation, fig. 5. During its application the patient should be recumbent, one hook being fastened to a staple, fig. 6, in the floor or wall, and the other to the noose in the lac encircling the limb. The cord should then be tightened, either by the surgeon himself, or by a trustworthy assistant, the operation being performed with all possible care and gentleness, so as not to endanger fretting of the muscles, fracture of the bones, or rupture of any of the soft parts.

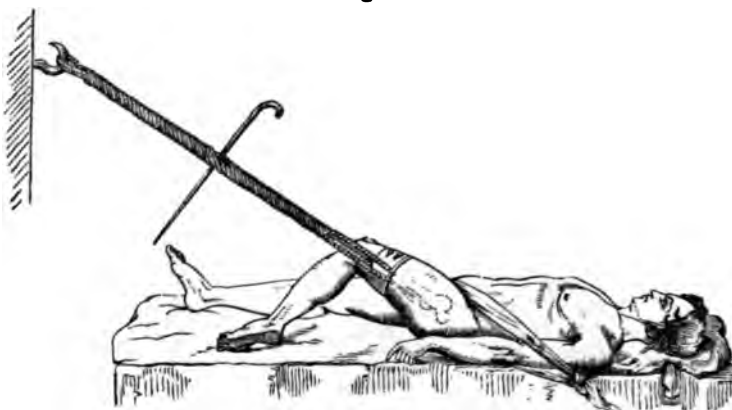
Fig. 6.



Staple.

A very ingenious contrivance, serving as a ready and efficient substitute for the pulleys, was suggested by the late Professor Gilbert. It consists in the use of a thin but strong rope, from four to eight strands of which are passed under the extending band, and doubled upon themselves. The free extremities are then drawn tightly, and secured to a staple in the wall. A stick is next carried across the centre of the strands, and revolved upon its axis as a double lever. In this manner a single assistant may furnish any amount of power that may be necessary for gradually and steadily overcoming muscular action, while the surgeon

Fig. 7.



Dr. Gilbert's Method of Extension and Counter-extension.

himself attends to the dislocated bone. The annexed cut, fig. 7, affords a good illustration of the apparatus as applied to the subject.

Another instrument of great power is the dislocation-tourniquet, fig. 8, of Mr. Bloxam, of London, which, although it acts upon the same principle as the multiplying pulleys, is a more convenient as well as a safer contrivance, capable of affording great aid in drawing the bone into its natural position in cases of unusual muscular resistance.

Of the surgical adjuster of Dr. Jarvis little need be said here. I have never employed it in recent dislocations, and in the repeated trials which I have made with it in those of somewhat long standing it has not been my fortune to meet with any marked success. It is an instrument of extraordinary power, and should, therefore, be used with great care and discretion. In the hands of its ingenious inventor it has doubtless been productive of benefit. Fig. 9 represents the adjuster as applied for the reduction of a dislocation of the hip-joint.

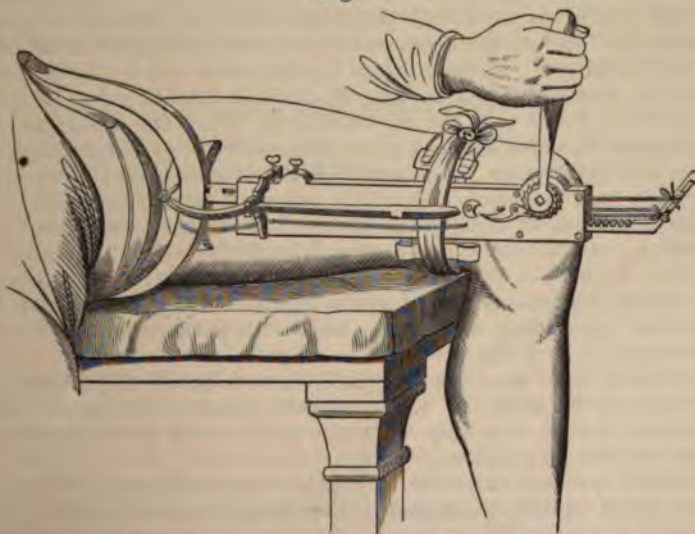
As the resistance of the muscles is one of the chief barriers to the reduction of dislocations, means, to which the term auxiliary is applied, are generally at once resorted to with a view to its counteraction. These means are both local and constitutional, and are particularly necessary in strong, robust individuals. The most efficient remedies of this class, formerly at the disposal of the surgeon, were copious blood-letting, usually carried to syncope, nauseating doses of tartar emetic, the warm bath, and the liberal use of anodynes. Sometimes the disgusting practice of intoxication by

Fig. 8.



Bloxam's Dislocation Tourniquet.

Fig. 9.



Jarvis's Adjuster, applied for the Reduction of a Dislocation of the Hip-joint.

alcoholic liquor was pursued; and Dr. Physick occasionally advised the smoking of tobacco to bring about the desired *relaxation*. Since the introduction of chloroform

and ether nearly all such means have become obsolete, these articles having very properly taken their place. Even bleeding is now seldom necessary, except occasionally where, from excessive muscularity of the patient, unusual difficulty is expected, or where, from the injury sustained by the soft parts, it is important to employ at once active measures for preventing excessive inflammation. Tartar emetic, the warm bath, and tobacco enemas have justly been proscribed. The patient is anæsthetized in the usual manner, and all manipulation is withheld until the system is completely relaxed and the mind rendered unconscious, when the operation is at once proceeded with, the action of the remedy being gently maintained until the object is accomplished. I have pursued this practice in every case of dislocation that has fallen under my notice during the last twenty years, and have every reason to be satisfied with the result.

A surgeon, called to a case of dislocation immediately after its occurrence, may occasionally succeed in effecting replacement by taking advantage of the faint and relaxed state in which he finds the patient from the shock he has sustained. Or he may succeed by diverting his attention, either by engaging him in conversation, or by a sudden expression of surprise, while he makes a forcible attempt at reduction. The mere idea of pain is generally sufficient to excite the muscles to spasmodic action, so as to oppose the efforts at restoration. It was, therefore, formerly a matter of great consequence to prevent this by a playful remark, an impertinent question, or an angry reply, designed to distract the attention of the sufferer, and to throw the muscles off their guard. Dupuytren is reported, upon one occasion, to have employed a similar, although less polite, expedient. Having been called to a lady of rank on account of a dislocation of the shoulder, he was for a long time foiled in his efforts; the assistants pulled, he pushed and pressed, and she shrieked and offered every possible resistance. His temper became ruffled, and he tried in vain to distract her attention. At last, said he, "Madam, I have repeatedly asked you how this accident happened, and you have as constantly deceived me; you have not informed me that you had been drunk." The woman, shocked at the remark, indignantly asked, "Who told you so?" "Your son, madam." The poor patient was stupefied, all the muscles became instantly relaxed, and in a moment the luxation was reduced.

As soon as the system is properly relaxed the surgeon proceeds to the reduction, trusting either to his own personal efforts, or employing such aids as the exigencies of the case may seem to require. When the extension and counter-extension have been maintained for some time, bringing thus the head of the displaced bone gradually nearer and nearer to its socket, he should grasp the part firmly, and thus assist in lifting it into its natural position. Or he may accomplish this by means of a band or fillet thrown across his neck and shoulder, while he makes strong and steady pressure against the head of the bone, pushing it back in the direction of the luxation or towards its fellow. In many cases the reduction will be facilitated if, at the moment the bone approaches its socket, the limb is rotated upon its axis, carried towards the body, or drawn over the opposite limb. When the replacement threatens to be unusually troublesome, the ingenious surgeon will not fail to employ all kinds of expedients and stratagems to accomplish his object, rather than abandon the patient to his fate with a useless limb. It is now well ascertained that almost every recent simple dislocation of every joint in the body may be effectually and expeditiously reduced by manipulation alone, especially if the patient is completely anæsthetized. Difficulty will be likely to occur only, or chiefly, in those cases of displacement in which the head of the bone has slipped through a very narrow opening in the connecting ligament, grasping the bone with extraordinary firmness, and so impeding its return to its proper position.

The restoration of the dislocated bone is indicated by the reëstablishment of the shape and motion of the joint; by a snap or noise heard at the moment of the reduction, but which is always very faint when the patient has been anæsthetized; and by a great and sudden diminution of pain.

Finally, it is always very desirable to effect replacement as speedily as possible, even although there should be considerable inflammation and swelling, and, consequently, a probability of inflicting some pain; for it is much better to pursue such a plan than to subject the patient to the risk of having, by the delay, an irreducible dislocation, of which there must always be some apprehension, especially when the injury involves a ginglymoid articulation. An exception to this rule must, of course,

be made when the joint is excessively swollen and tender, when a few days may be profitably spent in the employment of leeches, saturnine and anodyne lotions, antimonials, and other means, until the inflammation is sufficiently reduced to render the parts tolerant of the necessary manipulation.

In obstinate cases of dislocation, rendered so by the manner in which the bones are interlocked with each other, and in which the muscles passing over them are stretched like tense cords, the reduction is sometimes greatly facilitated by subcutaneous tenotomy. The expedient is particularly valuable in dislocation of the tarsal joints, but it may also be advantageously employed in displacement of the larger articulations, especially in those of long standing. The operation has often been successfully performed, without, so far as I am aware, having been followed by any bad results.

After-treatment.—When the reduction is completed, measures must be adopted, first, to prevent a recurrence of the accident, and, next, to limit inflammation, more or less of which must necessarily take place after every injury of this kind, however simple. The former of these objects is accomplished by appropriate bandages, or bandages and splints, with rest in the recumbent position, especially if the injury is seated in the lower limbs; in dislocations, on the contrary, of the upper extremity, the arm should be suspended in a sling, and the patient, after a few days, may walk about in the open air. Inflammatory accession is met by the usual antiphlogistic remedies, both constitutional and topical, among the latter of which evaporating lotions, as alcohol and water, and solutions of acetate of lead, along with laudanum, are the best, and they will generally be found most agreeable and beneficial, at least during the first forty-eight hours, if they are applied warm. Whenever the joint is so situated as to admit of the application of the roller, this is on no account to be omitted, as it serves both to support the parts and to prevent swelling. Its effects, however, must be most carefully watched, lest it cause undue constriction. Pain is subdued by full doses of morphia.

Finally, another object, one, indeed, of the first moment, is the prevention of ankylosis. Hence, as soon as the inflammatory symptoms have abated, passive motion should be instituted, and repeated, steadily and perseveringly, at first once, and afterwards twice, or even thrice, a day, until the functions of the joint are perfectly reëstablished; an object which can seldom be attained, in any case, under several months, and in some, indeed, not under six, ten, or twelve, depending upon the nature of the joint, the extent of the injury, the character of the treatment, and, above all, the coöperation of the patient, whose conduct has often much more to do with the production of a stiff and useless joint than his surgeon. After the more prominent inflammatory symptoms have disappeared, the absorption of effused fluids should be promoted by soap liniment, or moderately stimulating embrocations, followed, in due time, by the cold douche, dry frictions, and shampooing.

3. COMPLICATED DISLOCATIONS.

A complicated luxation, as stated elsewhere, is one where the displacement is accompanied by a fracture, the rupture of an important vessel or nerve, a violent contusion, or a wound communicating with the cavity of the articulation, or extending deeply among the tissues in its neighborhood. Not unfrequently several of these lesions coexist, thus materially increasing the gravity of the case, and the difficulty of managing it.

Although such an accident may occur in any of the articulations, it is by far more frequently met with in those of the elbow, wrist, knee, and ankle than in any other, for the reason, probably, that the heads of the bones are less protected there by muscles, and also that they are more sharp or angular, than in the orbicular joints. Hence, when the injury is unusually violent, the articular extremities, losing their ligamentous connections, are apt to be impelled with so much force against the soft parts as to lacerate them from within outwards, dividing muscles, tendons, fasciæ, vessels, nerves, and integument, and, perhaps, protruding several inches beyond the external wound; or, the vulnerating body, impinging forcibly against the external surface, may commit the mischief from without inwards, the bones being comparatively passive until the moment they are struck, when they, in their turn, may inflict additional injury upon the structures beyond where the projectile does not penetrate. In the great majority of instances, at least in civil life, the lesion is caused by falls,

blows, or kicks; in military practice numerous cases of complicated dislocations occur from gunshot injury.

Compound dislocations, as they are commonly called, appear to be very rare in comparison with simple. Thus, of 94 cases of dislocations, reported by Dr. Norris as having occurred in the Pennsylvania Hospital, only 2 were compound; and of 166 cases collected by Professor Hamilton, only 8 were of this description.

The *symptoms* of complicated dislocations are usually sufficiently characteristic, and do not, therefore, require any formal description. In general, there will be more or less distortion of the joint, inability of motion, discharge of synovial fluid, and shortening of the corresponding limb, with contusion, discoloration, and ecchymosis of the soft parts. When there is a wound, the end of the bone not unfrequently protrudes at the external opening; sometimes to the distance of an inch or two. Crepitation will, of course, be present when the dislocation is complicated with fracture. Great numbness and partial paralysis will indicate lesion of an important nerve; while coldness of the extremity, with absence of pulsation in its distal portion, and copious extravasation of blood, will be denotive of serious injury of the principal artery.

A complicated luxation, as the name implies, is always a grave accident, liable to be followed by the most dreadful consequences, jeopardizing the safety both of limb and life. The resulting inflammation is generally extremely violent, and is peculiarly prone to lead to abscess, erysipelas, and pyemia, especially in persons of intemperate habits, or of a dilapidated system. Under such circumstances, and sometimes even when the person was in the most perfect health just before the injury, the constitutional disturbance is usually very great, delirium sets in early, and the parts are soon seized with gangrene. The danger of mortification will necessarily always be proportionately great when there has been a division of an important vessel or nerve, interrupting circulation and innervation; pyemia will be most likely to happen when there has been excessive shock, and necrosis when the protruded or exposed bone has been stripped of periosteum, broken into pieces, or covered with dirt. But the danger to limb and life is not limited to the primary effects of the injury; often, after an attempt has been made to save the parts, the surgeon is chagrined to find that all his efforts have been unavailing, that the patient is gradually worn out by hectic irritation and profuse discharge, and that amputation, now performed as a dernier resort, hardly holds out a single prospect of cure. A guarded prognosis, then, is becoming in every case of complicated dislocation, however simple, if such a term is applicable to such a subject.

Treatment.—Much of our success in these accidents will depend upon the promptness and efficiency of our treatment, or the manner in which the parts are managed during and after the reduction, which should always be effected as speedily as possible, and with as much care and gentleness as the case will admit of, the patient being fully anesthetized. If any wound exist, the edges must be brought accurately together with adhesive plaster, aided, if necessary, by suture, and smeared over with collodion to exclude the air. Or, Mr. Lister's antiseptic dressing, described elsewhere, and at present so much employed in the treatment of compound dislocations, may be used; for, although there is every reason to believe that its efficacy has been much exaggerated, it, nevertheless, possesses a certain value as a "protective," and is, therefore, deserving of a fair trial, the more especially as it is not likely, if properly applied, to do any harm.

Any loose splinters of bone that may be present in these accidents are to be at once removed, care being taken not to interfere with any that are sufficiently adherent to render it probable that, if left, they will reunite. The fingers and forceps are the best instruments for performing the operation. If the end of the bone protrude at the wound, it must at once be restored to its natural position, any dirt that may cover it having previously been picked away, or removed with the syringe. Should it be girt by the integument, so as to render the reduction impracticable, a circumstance, however, which must be extremely rare, the opening must be carefully enlarged with the probe-pointed bistoury; and a similar practice should be followed when the wound is too small to admit of the easy extraction of loose fragments. If the end of the bone is very sharp, angular, or denuded of periosteum, it should be cut off with the saw or pliers, but such a step should only be taken after the most thorough conviction of its imperative necessity; for the same rule applies here as in the soft parts, to save all we can, and sacrifice nothing improperly. I can hardly

conceive of a case where it would be necessary to remove the end of a dislocated bone simply because it protrudes at a wound. If the patient is completely relaxed by chloroform, extension and counter-extension, with judicious coaptative pressure, could not fail to effect restoration, even when the bone is very tightly girt.

When ordinary means fail to overcome the resistance of the muscles, tenotomy may be employed, as originally practised by Mr. William Hey, in a case of compound dislocation of the ankle, and since repeated upon other joints by Dieffenbach and other surgeons.

Finally, when the luxation is complicated with fracture, the rule is to reduce the former before the latter is set, for the reason that if the restoration of the joint be postponed until the broken bone is repaired, it will often be impossible to effect it. Besides, the union might be destroyed under the effort. Under such circumstances, the reduction of the luxation is always greatly facilitated by putting up the fracture firmly in splints, as a longer and better leverage is thus secured.

The reduction having been effected, the joint and corresponding limb are to be enveloped in a bandage—that of Scultetus being passed around the wounded part—and placed securely in splints, or, what is preferable, in a wire case, or wooden box, in order to keep it perfectly at rest, and in as easy a position as possible. Pain and inflammation are relieved by the usual remedies; and it is here that anodynes will be likely to display their happiest effects, both in allaying suffering and in preventing serious constitutional disturbance. Antiphlogistics must be employed warily, with due reference to the effects of shock, long confinement, and copious drainage. In a word, the patient must not be purged and bled simply because he has a compound dislocation; on the contrary, such measures, if used at all, must be used with the greatest possible caution. The diet must be rigidly adapted to the exigencies of the case; as in all other severe injuries, it should be nutritious rather than otherwise, and instances will often arise where it should be decidedly so from the very commencement of the treatment. The enfeebled patient will often be immensely benefited by the addition of milk punch, whiskey, ale, or porter, especially if he was accustomed to any of these articles previously to the accident. In the event of suppuration or erysipelas, recovery will be materially aided by the use of quinine and iron.

The affected parts are handled as little and as gently as possible; all officious interference is refrained from; the secretions are removed from time to time with the sponge, and fetor is allayed with chloralum or permanganate of potassa. In case of wound, or much discharge, the limb should be placed in bran, which will answer the threefold purpose of maintaining equable pressure, absorbing the secretions, and affording a comfortable bed for the parts to rest upon, with the additional advantage, in hot weather, of preventing the formation of maggots.

Concerning the propriety of amputation, the same general rules are applicable as in complicated fractures, a subject duly discussed under that head. The following summary, however, respecting the operation, will not be out of place here. The reasons for immediate amputation are, first, the excessive contusion and laceration of the soft parts; secondly, the rupture of the principal artery or nerve of the limb, attended with other serious injury; thirdly, an extremely shattered state of the bones; fourthly, free exposure of a large joint; and, lastly, the advanced age, depraved habits, or ill health of the patient. Secondary amputation may be required, when, after an attempt has been made to save the limb, gangrene has taken place, or life is assailed by exhausting suppuration, consequent upon extensive disease of the soft parts, the joint, or bones, or of all these parts together. Very great or irremediable deformity of the limb, standing in the way of its usefulness, is also a just cause for amputation.

Instead of amputation, in some of the above cases, excision may occasionally be advantageously employed, either primarily or secondarily. The primary operation is particularly indicated in dislocations complicated with a shattered and comminuted condition of the head of the displaced bone, and has been so often performed beneficially that it may now be regarded as one of the established proceedings in surgery. Its greatest success has been obtained in compound luxations of the shoulder-joint. Even when there is no fracture of the head of the dislocated bone, but simply extensive laceration of the ligaments, completely detaching the parts from each other, it is questionable whether, in many cases, excision would not be the more expedient practice.

Secondary resection may be employed in caries, or caries and necrosis, of the ends of the bone, coming on after a fruitless attempt to save the parts.

4. CHRONIC, OLD, OR NEGLECTED DISLOCATIONS.

The subject of chronic, old, or neglected luxations has not received the attention which its importance merits. The morbid anatomy of these accidents is still imperfectly understood, no connected body of facts illustrative of it having yet been published, and it is to be feared that their treatment is seldom guided by sound scientific principles. They constitute a class of cases which almost every surgeon approaches with doubts and misgivings, being anxious to do something for the patient's relief, and yet afraid the interference should produce serious, if not irreparable, mischief. I candidly confess that I have always shared these feelings, and that I have never had charge of an old or neglected dislocation without a strong secret wish that it had fallen into other hands, such have usually been my disappointment and the anxiety attendant upon my efforts at reduction. The risk of rupturing an important vessel, perhaps the main artery of a limb, of breaking a bone, or of exciting extensive suppuration in the parts around the affected joint, with the more remote chance of inducing pyemia, is well calculated to cause one to hesitate before he enters upon an enterprise so fraught with unpleasant consequences.

The blood that is effused in dislocations, unless unusually abundant, is generally very soon absorbed, as after other accidents involving subcutaneous hemorrhage. On this account it is very seldom that an opportunity is afforded of meeting with any in chronic cases; it is only now and then that a small clot or stratum, decolorized, and partially organized, is seen, and even this is almost always eventually carried off. The inflammation consequent upon the lesion is constantly followed by a deposit of plastic matter, both in and around the joint, filling up the socket of the bone, and infiltrating the connective tissue, muscles, and other structures in the neighborhood. More or less of this substance is also effused around the displaced head, where it is gradually organized, and at length converted into an adventitious capsule, of a pale-grayish aspect, and of a dense, fibroid texture, not unlike the original capsule, with which it generally communicates by one or more openings, and which, by degrees, becomes wasted and attenuated from want of use. The muscles, in great measure deprived of their functions, are transformed into pale, rigid,

contracted bands, which, in time, often undergo the fatty degeneration. The periosteum, near the joint, is usually somewhat thickened, and occasionally studded with osseous stalactites. The cartilage of the affected socket is generally partially absorbed, or more or less changed in its appearance, texture, and consistence, while that which invests the head of the bone exhibits a rough, scabrous aspect, being thickened at one point and atrophied at another, the osseous substance itself often becoming hard and sometimes even eburnized. Few opportunities have occurred of observing the condition of the vessels and nerves in ancient dislocations; in the cases in which this has been noticed, the former were found to be preternaturally

Fig. 10.



Old Dislocation of the Hip, a new Acetabulum being formed, while the Original one is but little Changed.

flexuous, to accommodate themselves, as it were, to the displaced bone, and the latter somewhat attenuated, but otherwise sound.

In those cases in which the displaced head enjoys a good deal of freedom, it generally forms for itself a sort of socket, as in fig. 10, most commonly in a neighboring bone, but sometimes in the substance of a muscle, or partly in the one, and partly in the other. This socket, however, although it may admit of considerable motion,

is a very imperfect type of the original, as is also the new ligament by which it is surrounded.

In addition to the changes now described, and which, it will be perceived, relate exclusively to the articular structures and to the parts immediately around, changes which are usually the more conspicuous in proportion to the duration of the dislocation, it will be found that the whole limb below the seat of the injury, and sometimes even for some distance above it, has a shrunk and withered appearance, its muscles being thin, flabby, and wasted, and its temperature materially diminished. In many cases it is affected with rheumatic or neuralgic pains, subject to aggravation with every change of the weather and with every disorder of the general health. The motion of the new joint is necessarily much restricted, and is often performed with a peculiar grating noise and sensation, caused by the roughened state of the contiguous surfaces, and the entire absence of synovial fluid. When all motion is lost, the joint gradually undergoes complete bony ankylosis.

It has long been a question with surgeons at what period after the occurrence of a dislocation it should be considered as impracticable to effect reduction. The question, as might have been expected, has been differently answered by different observers, and by the same observers for different joints. Thus, Sir Astley Cooper, who has always been regarded as a leading authority upon the subject, thought that three months for the shoulder, and eight weeks for the hip, might be set down as the limit, beyond which any efforts of this kind, except in persons of very lax fibre or advanced age, would be highly imprudent; an opinion which accords so well with general experience as, in my judgment, to entitle it to be considered as a law. It cannot be denied that this law has exceptions, but this only serves the more fully to establish its validity. Thus, in relation to at least one of the joints in question, that of the shoulder, a considerable number of cases have been reported of reduction at from four to seven months after the receipt of the injury. Indeed, Dr. Nathan Smith, of New Haven, met with one in which he succeeded completely nearly one year after the accident. Examples of reduction of dislocations of the hip-joint from three to six months' standing have also occurred, although it will be found, upon careful inquiry, that their number is exceedingly small.

For the ginglymoid articulations the period is still more limited, although, in this respect, it varies a good deal among themselves. In relation to the elbow-joint, which is the best type of the ginglymoid class, I have found, in a very considerable number of cases, that any attempts at reduction, however perseveringly or judiciously continued, will generally prove completely abortive after the third week. On the contrary, the wrist-joint may generally be rectified at a considerably later period. These differences in the reducibility of dislocations of different articulations are due altogether to peculiarities of structure and to the amount of inflammation consequent upon the injury. The surfaces of the orbicular joints are comparatively smooth and simple, and their displacements are seldom followed by much inflammation; the reverse in both particulars being true in regard to the ginglymoid joints.

Evidently, then, every luxation must rest, so to speak, upon its own merits, so far as the question of its restoration is concerned; for, as has just been stated, while one joint becomes irreducible in a fortnight or a month, another, differently constructed, may remain reducible eight weeks, or even a much longer period. A far better rule by which to decide this question is to judge by the extent of motion of the affected bones, the previous attempts at replacement, and the degree of inflammation consequent upon the injury. If the joint is very stiff and tender, if the luxated head has contracted firm adhesions, involving, perhaps, a large artery, or some other important structure, and if, in addition to this, there is reason to believe that the socket is filled up with new matter, any effort at reduction would not only prove abortive, but might be followed by very serious accidents, jeopardizing limb and life. Cases in which severe injury and even death have been the consequence of long-continued and violent attempts at reduction have happened to surgeons of great experience and eminence, and should serve as warnings to the young practitioner against the employment of undue force where the prospect of success is at all doubtful.

The conduct to be observed in the reduction of chronic dislocations resolves itself into a few simple rules. In the first place, it is necessary, as an important preliminary, to prepare the part, as well as the constitution, for the operation, by the systematic movement of the joint, and by light diet and purgatives, aided, if the person

is at all strong and plethoric, by at least one large bleeding. The object of this depletion is not so much to weaken the muscles as to lessen the risk of severe inflammation and the formation of abscesses. The motion of the joint is intended to break up any abnormal adhesions that the bone may have contracted with the surrounding tissues, and should be conducted with great care and gentleness, the corresponding limb being carried about in different directions, flexed, extended, depressed, elevated, adducted, abducted, rotated, and circumducted; the operation should not be performed, at first, oftener than once a day, but by degrees it may be repeated every twelve hours, and it should be steadily continued for at least a fortnight, free use being made all along of evaporating and sorbefacient lotions, with minute doses of mercury, to promote the absorption of effused plasma.

This preliminary treatment having been gone through with, and the patient being thoroughly anæsthetized, the extension and counter-extension are to be conducted in the usual manner, only with more care and patience, and with an additional number of assistants. The object is not, as in recent luxations, to fatigue the muscles, but to extend and stretch their fibres, shortened, hard, and tense from long-continued disease and inflammatory irritation. In no event should the surgeon employ violent or forcible measures, because such a procedure would be sure not only to increase the resistance, and, as a necessary result, the difficulties of the reduction, but be very likely to cause dangerous laceration of the soft parts, and secondary mischief. If the operation fail, it must not be too soon repeated, but some time must elapse before another attempt is made, special attention being meanwhile paid to the suffering joint in the way of support and fomentation. The rupture of an important artery, as, for example, the axillary in dislocation of the shoulder, will be denoted by a rapid effusion of blood into the connecting cellular tissue, discoloration of the integument, and cessation of pulsation in the distal portion of the limb. The proper remedy, in such an event, is immediate ligation of the affected vessel, and the avoidance, of course, of further interference. Should fracture occur, the operation must also at once be suspended, and the case treated upon general principles.

In order to facilitate the reduction of old dislocations, resisting the ordinary efforts, Dieffenbach proposed the subcutaneous division of the muscles concerned in opposing the restoration of the bone, and such an operation has repeatedly been performed, although rarely with the advantage that had been anticipated. I have myself occasionally employed it, but never with any decided benefit. The great objection to the procedure is the danger of wounding important structures, especially large vessels and nerves, which are very often greatly displaced, and which, if injured, might occasion serious consequences. No one, therefore, should undertake such an operation unless he has the clearest possible conceptions of the anatomy of the parts, and is fully prepared to meet any emergency that his knife may produce.

The constant and excessive suffering which sometimes attends an unreducible dislocation of the shoulder-joint, from the pressure of the humerus upon the brachial plexus of nerves, can only be relieved by the excision of the head of the bone; an operation which, so far as I know, was first performed by Professor Edward Warren, of Baltimore, in 1869. His patient was a female, fifty years of age, who, twelve months previously, in a fall, had luxated the humerus, throwing it down into the axilla beneath the coracoid process in contact with the brachial plexus of nerves, occasioning violent and persistent pain, with great debility and gradual emaciation. The joint was exposed by a V-shaped incision, and the head of the bone, firmly wedged in its new position, divided through the surgical neck. The patient rapidly recovered with a good use of the arm. The precedent set in this case cannot fail to be followed by other surgeons, as the operation holds out the only chance of relief from the frightful suffering entailed by such an accident.

5. CONGENITAL DISLOCATIONS.

There are certain dislocations which exist at birth, and which are, therefore, denominated congenital. Their occasional occurrence, recognized at an early period of the profession, has been satisfactorily established by a number of modern observers, especially by Chaussier, Paletta, Dupuytren, Breschet, Pravaz, R. W. Smith, Guérin, and Carnochan.

Different joints are liable to this variety of luxation, but its occurrence is by far

most common in those of the hip, wrist, and shoulder. The lesion, although generally single, is sometimes double, existing simultaneously in the two opposite articulations. Occasionally it occurs in different joints in the same subject, as, for instance, in the shoulder and wrist, or in one of these joints and in that of the hip. Both sexes are liable to it, but by no means in an equal degree, observation having shown that females suffer much more frequently than males in the proportion, as nearly as can be ascertained, of at least three to one; a fact too constant to be altogether dependent upon chance. Of twenty-six cases of congenital dislocation of the hip, noticed by Dupuytren, not above four occurred in males.

Congenital luxation is sometimes hereditary. Instances have been recorded in which it appeared in a number of successive generations, and also in several members, of the same family.

The *causes* of congenital dislocations have excited much attention, as well as a great deal of controversy, without eliciting any positive results. The various theories that have been advanced in explanation of this vexed subject may be arranged under the following heads:—1st, external violence inflicted upon the fœtus; 2dly, disease of the articulations; 3dly, arrest of development.

1st. There can be no doubt that undue force exerted upon the fœtus, whether from without, as when the mother receives a fall or blow upon the abdomen, or from inordinate contraction of the uterus, is capable of inducing partial dislocation of the joints, or, at all events, such a state of the articulating surfaces as to predispose them strongly to its occurrence. It is well ascertained that external violence is capable of producing fractures of the fœtal bones: I have myself seen several remarkable examples of this kind, and Chaussier has recorded a case in which this lesion coexisted with congenital luxation of the hip and shoulder joints. It is extremely probable that a deficiency of the amniotic liquor may predispose to this occurrence, by enabling the womb to exert its contractile force more readily and fully upon the fœtus, thus forcing the articulating surfaces away from each other at a time when they are too imperfectly developed to resist such pressure, especially if frequently repeated. A theory of the formation of clubfoot, which is probably nothing originally but a partial displacement of the tarsal joints, has, as is well known, been founded upon this supposed contractile power of the uterus, and of its injurious influence upon the fœtus. Finally, there is reason to believe that what is termed a congenital luxation is occasionally produced by violence inflicted upon certain joints during delivery, in rude and forcible attempts to bring away the extremities.

2d. The second theory rests upon the idea that the lesion may depend upon disease of the joints, awakened prior to the child's birth. This is extremely plausible; at all events, it is impossible not to be impressed with the conviction that disease may occasionally be followed by such a result, if not directly, at any rate by inducing relaxation of the ligaments, and so favoring the action of the muscles in separating the articular surfaces. Children in the womb are, it is well known, liable to numerous affections, some of them of a highly inflammatory character, terminating at one time in death, and at another in serious and irremediable deformity. Of these affections, synovitis is one, and it is probable that it generally has a gouty, rheumatic, or syphilitic origin.

3d. The theory of an arrest of development has many advocates, both in regard to the origin of this and of other affections; but what do we know of it? Certainly nothing beyond the fact that it is expressive of the imperfect growth of a part, and of the concomitant deformity; it affords no clue whatever to the nature of the causes, either remote or proximate, that induced it. The fault may exist in the germ, or it may be superadded to it after conception, in consequence of some intrinsic defect, or as a result of the operation of causes acting through the mother.

The *pathological* changes accompanying this lesion are numerous and diversified. In the first place, the dislocated articular extremities are generally deprived, in part, if not entirely, of their natural shape and structure; they are rounded off, divested of synovial membrane and cartilage, atrophied, and otherwise altered. The deepest cavity, as, for instance, the cotyloid, often completely disappears, not by being filled up with plastic matter, as in traumatic luxation, but by the absorption of its component elements. Very frequently the displaced bone forms a new socket, generally superficial, but quite sufficient for the amount of motion to which it is restricted. The ligaments are elongated and relaxed, thin, ribbon-shaped, partially wasted, or

completely destroyed; occasionally, however, instead of being stretched and attenuated, they are very short, tense, and strong, obviously from interstitial deposits. The surrounding muscles are either pale, wasted, and partially transformed into fatty matter, or they are unnaturally large and stout, from the increased exercise devolved upon them by the dislocated bone.

The *symptoms* of congenital dislocation are characteristic. The affection, manifesting itself in various kinds of deformity, is noticed at, or soon after, birth, having commenced without any apparent violence; it is unattended with pain, or, if pain is present, it is much less than in the traumatic form of dislocation; the swelling also is inconsiderable, if, indeed, there is any at all; the head of the bone can be felt in its abnormal position, and the portion of the limb connected with it is generally singularly distorted, being changed in its axis, flexed, extended, or twisted. Motion is either much impeded, or too free; the affected member is commonly somewhat shortened, and more or less attenuated, from the wasted condition of its muscles. By extension and counter-extension the displaced surfaces may generally be easily restored to their natural position, but the moment they are discontinued they resume their former condition. This is practicable, however, only in the younger class of subjects; in old cases, reduction is always proportionately difficult, often impossible. The deformity invariably increases with age, and is sure to be followed by an arrest of growth of the surrounding structures.

The *prognosis* is altogether unfavorable. This is particularly true of the lesion when it is of long standing, as when the person has attained the age of puberty or of manhood, when no plan of treatment that has yet been devised can be of any material, if, indeed, of the slightest, avail, owing to the impossibility of effecting accurate adjustment of the articular surfaces, in consequence of the organic changes which they have undergone. Even under the most propitious circumstances, as it respects age and preservation of structure, the difficulties of effecting a permanent cure will generally be extremely great, well calculated to exhaust the patience both of the subject and the surgeon. The prognosis should, therefore, always be very guarded.

Treatment.—From what has been stated, it is evident that the sooner the treatment of this lesion is commenced the more likely will it be to be successful, or, if not altogether successful, productive of amelioration. The two leading indications obviously are to effect reduction, and to prevent a recurrence of the displacement. No difficulty is generally experienced in fulfilling the former, especially in very young and tender subjects; it is the latter that causes all the trouble, annoys the patient, and frets the surgeon. Various kinds of apparatus, much of it of a very complicated and expensive character, have been devised for retaining the parts in contact after they have been restored; but it admits of doubt whether most of it could not advantageously be replaced by more simple means, such as ordinary splints, wire cases, and adhesive strips and rollers, which might be so applied as, in most cases, to answer the purpose most perfectly. Permanent extension and counter-extension will be required when there is retraction of the dislocated bone. Long confinement, however, should always, if possible, be avoided, as it is of paramount importance to preserve the general health. The principal local remedies, worthy of attention, are the cold douche and friction with ammoniated and other liniments, together with direct support. If the patient is feeble and anemic, benefit will accrue from the use of tonics, as iron and quinine, a nutritious diet, and exercise in the open air.

When the reduction of these dislocations is opposed by the permanent contraction of the muscles, the only way to overcome the obstacle is tenotomy. The case should afterwards be treated upon the same principles as in clubfoot.

SECT. II.—DISLOCATIONS OF PARTICULAR JOINTS.

1. HEAD AND TRUNK.

DISLOCATIONS OF THE HYOID BONE.

The possibility of a dislocation of this bone, at one time strenuously denied, has of late years been attested by a number of well-authenticated examples. In 1848, Dr. Ripley, of South Carolina, read a paper upon the subject before the Medical

Society of Paris, in which he described such an accident as having occurred in his own person; and Dr. Gibb, of London, declares that he has seen not less than four cases of it, all of them in the male sex. In one of these there was an occasional displacement of the left horn of the hyoid bone, the patient perceiving a sudden click in that part of the neck, and a sensation as if something were sticking in his throat. He at length died of phthisis, when it was ascertained that the thyro-hyoid articulation contained, besides a considerable quantity of clear fluid, a large sesamoid bone, the whole arrangement being such as to admit of an extraordinary amount of motion.

The reduction is effected by throwing the head backwards as far as possible, so as to put the muscles of the neck completely on the stretch, and then relaxing the lower jaw, at the same time that gentle pressure is made upon the displaced part. The bone, in the case of Dr. Ripley, always returned with a click.

DISLOCATIONS OF THE JAW.

The connection between the lower maxillary and temporal bones is established by a hinge-joint, each condyle of the former moving upon an interarticular cartilage, and being held in place by two ligaments. Luxation, therefore, can occur only in one direction, that is, forwards and downwards, the condyle slipping off the articular eminence of the temporal bone into the zygomatic fossa, as in fig. 11. The displacement is usually double, affecting both sides simultaneously, and is commonly produced by some sudden, spasmodic contraction of the muscles in yawning, laughing, vomiting, or convulsions. Dorsey has recorded the case of a female who luxated her jaw in the act of scolding her husband. The accident has sometimes happened in an attempt to extract a tooth, to bite a large apple, or to crack a nut. Occasionally it arises from a blow, fall, or kick upon the chin, the mouth being widely opened at the moment, and the condyle advanced upon the articular eminence. In 1861, I saw a female, twenty-nine years of age, a patient of Dr. Emile Fischer, who dislocated her jaw on both sides in an attempt, during an attack of delirium, to pull her tongue out of the mouth. Dr. Guignier met with an instance consequent upon a laryngoscopic inspection. More frequent in women than in men, and in middle-aged and delicate subjects than in the old and robust, it is extremely rare in young children, owing to the peculiar conformation of the body and branches of the jaw rendering the occurrence one of great difficulty. A case has been reported by Chassaignac in which, in a fall from a great height on the chin, one of the condyles of the jaw was driven through the temporal fossa into the skull.

The *symptoms* are generally characteristic. The mouth, as exhibited in fig. 12, is widely opened, and cannot possibly be closed; the chin is unusually prominent, and the lower line of teeth projects considerably beyond the upper; the saliva, increased in quantity, dribbles off involuntarily; deglutition and articulation are performed with great difficulty; the cheeks and temples are flattened, and, as it were, elongated; the coronoid process is easily distinguishable in the zygomatic fossa, especially if examined through the mouth; and, instead of the natural prominence formed by the external condyle immediately in front of the ear, there is a

Fig. 11.



Double Dislocation of the Lower Jaw.

Fig. 12.



Dislocation of the Lower Jaw.

distinct vacuity capable of receiving the end of the finger, although not without some effort, owing to the great tension of the integument. When the displacement has existed for some time, the symptoms will be less marked, but still sufficiently characteristic to prevent mistake, provided the surgeon takes the requisite care to inform himself of the history of the case and of the actual condition of the jaw and mouth. Notwithstanding this, a very ridiculous error has occasionally been committed, as in an instance which came under my observation in a middle-aged woman, who, in an attack of cholera, luxated the lower jaw, the accident being mistaken for tetanus. An error has occasionally been made after apoplexy attended with paralysis of the muscles of one side of the face.

When the luxation remains unreduced, the jaw, in time, partially regains its motion, the dental arches approaching each other, so that, eventually, the patient may even be able to masticate his food; speech and deglutition also improve; the saliva ceases to dribble; and much of the disagreeable deformity disappears.

The patient, during the *reduction*, may sit upon the floor or upon a low stool, his head being well supported by an assistant. The surgeon, standing in front, introduces his thumbs, carefully defended with a piece of roller, into the mouth, as far back as possible upon the large grinders, while he places the fingers of each hand under the chin and base of the jaw. Using now his thumbs as fulcrums, he forcibly depresses the back part of the jaw, to disengage the condyles from their position in the zygomatic fossæ, and at the same moment elevates the chin with his fingers, thus converting the bone into a lever of the first kind. Or, instead of this, the thumbs being placed as before, the surgeon grasps the angles of the jaw with his fingers, and, while the patient opens his mouth, the slightest downward pressure will be sufficient to disengage the necks of the condyles from the transverse root of the zygomatic processes of the temporal bones, thus enabling the temporal and masseter muscles to effect the reduction. The return of the condyles is generally indicated by a loud snap, and the instant it is about to occur the surgeon quickly removes his thumbs from the teeth, lest, in the act of closure of the jaw, they be seriously injured by the suddenness and violence of the contraction.

Such is the mode of reduction usually recommended by writers; in my own practice, however, I find that the operation is greatly simplified by the use of anæsthesia, which, while it completely relaxes the muscles, obviates the necessity of removing the thumbs from the jaw as the bone is sliding noiselessly into its place.

A very simple and efficient method of reducing dislocations of the lower jaw has been recommended by Nélaton. The patient being seated upon a chair, and the mouth widely opened, the surgeon, standing behind him, plants his thumbs upon the upper part of the nape of the neck, and then with the fingers pushes the jaw forwards by pressing against the prominence formed on each side of the cheek by the point of the coronoid process. A small amount of force generally suffices to effect the object, the condyles returning with a distinct snap. When the resistance is unusually great, the head may be supported by an assistant, or a band may be passed around it, in which the operator engages his fingers, while the thumbs, resting upon the cheeks, are made to bear upon the coronoid process from above downwards, and from before backwards.

The older surgeons were in the habit of reducing luxations of the lower jaw by placing between the molar teeth two pieces of cork or wood, which they used as fulcrums to depress the back part of the bone, while they raised the chin by means of a bandage. Another method, occasionally employed by them, consisted in pressing a stick against the lower grinders, so as to keep the jaws separated until the irritated and contracted muscles, overcome by fatigue, allowed the condyles to glide into their natural situation.

In unilateral displacement of this bone, the chin is thrown towards the opposite side; the parallelism of the front teeth is lost; the mouth is open, but less widely than in the double luxation; speech and deglutition are somewhat impeded; and the depression in front of the ear is perceptible only on the injured side. The reduction is effected upon the same principle as in the other form of the accident, with the difference that only one thumb is used. Tartra met with a case of unilateral dislocation of the jaw in a child only fifteen months old.

After both of these luxations, but especially the bilateral, the patient should for some time avoid opening his mouth, as the accident is extremely liable to recur from

very slight causes. The safest plan, therefore, is to support the jaw with an appropriate bandage, as that, for example, used in fracture. During the first few weeks the nourishment should consist exclusively of slops and of other articles that do not require mastication.

In neglected cases of this dislocation the reduction will generally be found to be very difficult even as early as the end of the third or fourth week. Occasionally, however, it will succeed after a very long interval, as in an instance reported by Mr. Donovan, where restoration was effected on the ninety-eighth day. When the ordinary means fail, instead of abandoning the patient to his fate, the efforts at reduction should be aided by the subcutaneous section of the external pterygoid, masseter, and temporal muscles.

There is a rare species of displacement of the lower jaw, first described by Sir Astley Cooper under the name of *subluxation*, which, apparently, depends upon an unusual laxity of the ligaments, permitting the condyle to slip off the interarticular cartilage. It is most common in weak, delicate females, and is characterized by inability to close the mouth, with more or less pain, and a feeling of tension on the injured side. If the bone do not return of its own accord, as it generally will, replacement may easily be effected by drawing the jaw slightly forwards and downwards, so as to afford the condyle an opportunity of reinstating itself upon the interarticular cartilage. When the relaxation of the joint is very great, the case must be treated with tonics, as iron and quinine, the cold shower-bath, electricity, exercise in the open air, and the application of a series of little blisters over the affected part.

A *congenital* dislocation of the lower jaw has been observed in a few cases, Mr. Robert W. Smith having been the first to notice such an accident, of which he has given, with great minuteness, the results of the dissection. The patient, an idiot from infancy, died at the age of thirty-eight. The luxation existed on the right side, which was remarkably deformed, having a singularly hollow appearance, which strikingly contrasted with that of the sound one, which was unusually full and plump. The extremity of the finger could readily be pressed between the posterior margin of the jaw and the external auditory canal, owing, as was found on dissection, to the absence of the condyle of the bone, which was, in fact, greatly atrophied nearly as far forward as the symphysis. There was no interarticular cartilage, or distinct capsular ligament; and both the masseter, pterygoid, and temporal muscles were much wasted. The temporal, malar, superior maxillary, and sphenoid bones were imperfectly developed, and the glenoid cavity existed merely in a rudimentary state.

DISLOCATIONS OF THE CLAVICLE.

Dislocation of the clavicle, compared with fracture of this bone, is extremely uncommon, there being probably fifty cases of the latter to one of the former. The cause of this remarkable difference is to be found in the exposed situation of the bone, and the great shortness and strength of its ligaments, which render it much more liable to yield in its continuity than at its articulations with the sternum and scapula. The displacement may occur at either joint, and several instances have been recorded where both were simultaneously affected.

1. The *sternal extremity* of the clavicle may be dislocated forwards, backwards, and upwards, the relative frequency of the accident being in the order here stated. Luxation downwards is rendered impossible by the resistance offered by the cartilage of the first rib.

Dislocation *forwards* is generally produced by injury inflicted upon the top of the shoulder, or by falls upon the elbow when the arm is separated from the trunk. The clavicle, being thus impelled violently forwards and inwards, completely ruptures the sterno-clavicular ligaments, and presents itself, along with the interarticular cartilage, in front of the upper part of the sternum. The sterno-cleido-mastoid muscle is pushed down, and some of its inner fibres are occasionally lacerated, particularly when they take their origin unusually near the joint.

The signs are, a hard, circumscribed, incompressible tumor at the upper and anterior part of the sternum, a vacuity at the natural situation of the joint, unusual prominence of the inner portion of the sterno-cleido-mastoid muscle, depression of the shoulder, and inclination of the head towards the affected side. The most reliable

evidence, however, of the nature of the accident, is derived from tracing the outline of the bone with the finger of one hand, while the shoulder is moved by grasping

Fig. 13.



Dislocation of the Sternal End of the Clavicle.

the elbow with the other, and by recollecting that in dislocation the bone retains its normal length, while in fracture it is materially shortened. The head of the clavicle overlaps the sternum, and is always, as in fig. 13, directed downwards, so as to enable the examiner readily to distinguish the articular surface from which it has been removed.

The reduction is effected easily enough, but unfortunately it is retained with so much difficulty that, despite the best directed efforts of the surgeon, hardly an instance recovers without some degree of deformity. Many years ago I had a case of this kind under my charge, which, notwithstanding the most vigilant care and attention, was as bad, as it respected the cure, at the end of three months, as it was on the day it happened. Since then I have met with several similar examples.

The articular cavity of the sternum is so shallow, and the ligaments unite with so much difficulty, that it is almost impossible to keep the parts in apposition sufficiently well or long to obtain complete consolidation. Fortunately, however, this occurrence does not materially affect the movements of the shoulder, for experience has shown that these are very soon entirely reestablished. It is a matter, therefore, simply of deformity, not of utility.

To reduce this luxation, one hand should be placed, shut, in the axilla, while the other grasps the elbow, which is then to be raised in order to push up the humerus, and thus convert it into a lever, acting directly upon the clavicle and scapula. The shoulder is next carried upwards, outwards, and backwards, in a direction opposite to that of its displacement, and the forearm brought forwards across the chest, so that the thumb and fingers shall rest upon the sound collar-bone. If by this manœuvre the articular surfaces do not resume their natural relations, the reduction should be promoted by pressing the luxated head of the clavicle backwards and slightly upwards. A wedge-shaped pad, with the thick end upwards, being placed in the axilla, the limb is firmly secured to the side and front of the chest by the ordinary immovable fracture apparatus, or, what often answers very well, the adhesive-strip dressing, a stout, square compress being applied directly over the sterno-clavicular articulation. The dressing must be frequently inspected, with a view to its readjustment, and be worn, with great constancy and regularity, for at least three months.

Dislocation *backwards* is generally produced in an indirect manner by injury applied to the shoulder impelling the scapula and the outer extremity of the clavicle forwards. It may also be caused by a severe blow upon the inner end of the bone, by the body being crushed between two resisting objects, and by violent traction upon the upper extremity when the trunk is firmly fixed and inclined backwards. The distinctive sign is that the head of the clavicle is forced backwards, and that it can be felt behind the summit of the sternum, sometimes below, at other times above, the level of that bone. A vacuity exists at the natural situation of the joint, the shoulder is directed somewhat forwards, the arm hangs uselessly by the side, and there is generally considerable dyspnoea, with cerebral congestion, and difficulty of deglutition, from the pressure of the luxated bone upon the trachea, cervical vessels, and œsophagus. The ligaments are completely ruptured, and the sterno-cleido-mastoid muscle is partially separated from its sternal attachments.

The reduction is effected upon the same principles as in the dislocation forwards, the fist being placed in the axilla and used as a fulcrum, while the shoulder is pushed upwards, outwards, and well backwards, and retained in this position by an appropriate apparatus, of which a figure-of-8 bandage, with a long, thick, square compress between the shoulders, is one of the best. Whatever means, however, be employed, it will be found extremely difficult to keep the articular surfaces in apposition and to prevent deformity. When the reduction is unusually obstinate, as it sometimes is when the head of the bone is firmly wedged in behind the sternum, the knee should be placed between the shoulders, the affected one of which should then

be drawn forcibly backwards and outwards, the arm being at the same time extended nearly at a right angle with the trunk.

This variety of dislocation is sometimes produced by deformity of the spine, allowing the shoulder to sink gradually forwards so as to push the head of the bone from the sternum. In a case of this kind, reported by Mr. Davie, of England, the clavicle compressed the œsophagus so severely as to cause great difficulty in swallowing, and danger to life by starvation. As reduction was impracticable, the trouble was remedied by sawing off the sternal end of the bone about one inch from the articulation. The patient speedily recovered, and lived six years after the operation.

Luxation upwards is so extremely rare that many of the best surgeons formerly doubted the possibility of its occurrence. The cases, however, that have been reported by Macfarlane, Baraduc, Malgaigne, and others, fully establish its claims to the character of a distinct species. The accident generally results from violence inflicted upon the shoulder, as a blow or fall, driving the scapula downwards and inwards towards the chest, thus separating the bone from its connections, and forcing it upwards above the fourchette of the sternum. The symptoms are usually very characteristic. The bony tumor can be distinctly felt and seen in front of the trachea, where it is easily impressed by moving the corresponding arm; the shoulder, sunk forwards and downwards, approaches nearer to the median line than naturally; there is a remarkable interval between the clavicle and the cartilage of the first rib, amounting to from six to twelve lines; the sterno-cleido-mastoid muscle is put upon the stretch; and there is a vacuity at the joint, as in the other forms of the accident. The reduction is very easily effected, simply by lifting the shoulder thoroughly away from the chest, at the same time that it is slightly elevated and inclined backwards, and pressure made directly upon the luxated head. Retention will be facilitated by placing a pad in the axilla, and supporting the elbow and forearm well with adhesive strips and bandages. The union is generally imperfect, but this does not materially weaken the functions of the limb.

2. The *acromio-clavicular* articulation is formed by the acromion process of the scapula and the outer extremity of the clavicle, by a species of arthrodia, the concave surface of the former being closely adapted to the convexity of the latter, and the union established by strong ligamentous bands. Admitting hardly of any motion, it can be dislocated only by external violence applied either directly to one or the other of the two bones, or indirectly through the arm and sternum. The accident is usually attended with severe contusion of the soft parts, and is seldom so thoroughly repaired as not to be followed by some degree of deformity, although the recovery of the motions of the limb is eventually sufficiently perfect for all useful purposes.

The scapular end of the clavicle may be thrown from its natural position in three different directions; upwards, above the acromion process, downwards and backwards, beneath this prominence, and downwards and forwards, under the coracoid process. Of these luxations, the first is by far the most frequent, both the others being extremely rare.

In the dislocation *upwards*, the end of the clavicle, breaking away from its articular connections, is thrown up by the action of the trapezius muscle, or by the impelling force, so as to overlap the acromion process, as in fig. 14, and form a small, hard, round tumor immediately beneath the skin, which disappears upon raising the arm, but is reproduced the moment we let go our hold. The head is inclined towards the injured side, the limb hangs closely along the trunk, the shoulder looks as if it were somewhat flattened, and the patient is unable, without great pain and difficulty, to carry his hand to his mouth; in a word, the whole attitude of the body is nearly the same as in fracture of the clavicle. The accident is usually caused by a blow upon the shoulder, and the circumstance of the trunk being strongly impelled forwards promotes the luxation by increasing the

Fig. 14.



Dislocation of the Acromial End of the Clavicle.

strain. It may also be occasioned by a fall upon the elbow, and by a kick upon the acromion process. However induced, there is necessarily, in the complete form of the lesion, a rupture not only of the acromio-clavicular ligaments, but also of the ligaments connecting the clavicle with the coracoid process. In the incomplete luxation the latter always escape.

The clavicle readily resumes its natural position by drawing the shoulders upwards and backwards, while the knee is interposed between them behind, as the patient sits upon a chair. To maintain it in this situation, the same apparatus and dressings must be used as in fracture of this bone, and in the sterno-clavicular luxations, already described. A thick pad, with the base directed upwards, is placed in the axilla, and the arm and forearm must be well secured to the chest. Direct pressure by means of a stout compress and piece of sheet lead should be made upon the acromio-clavicular junction. Despite, however, all the precaution, care, and skill of the surgeon, he will seldom be able to procure a good cure. I have seen cases of this description treated for months with the most determined effort to succeed, and yet at the end of this time it was impossible for the patient to move his arm without causing a relapse.

Dislocation *downwards*, appropriately named *infra-acromial*, is exceedingly uncommon, only a few cases of it having been reported. The fact is, although it was described by J. L. Petit, who believed it was more frequent than dislocation upwards, it has been almost entirely ignored by modern systematic writers. It has been alleged that the accident cannot happen without previous fracture of the coracoid process, a conjecture which has been satisfactorily disproved by experiments performed upon the dead subject.

The accident, in a few cases that have been carefully studied, has been the result of violence upon the shoulder, as a heavy blow, or a kick from a horse, and it can hardly be imagined that it could be produced in any other manner. It is probably, in every instance attended with a rupture of the coraco-clavicular ligaments. The characteristic sign is the situation of the end of the clavicle beneath the acromion process, which is at the same time remarkably prominent, and somewhat nearer to the sternum than in the natural state. The shoulder is flattened, and the arm, applied close to the side, is incapable of voluntary motion. Where the evidence is so distinct, error of diagnosis must be impossible. Should any doubt, however, arise upon the subject, it may easily be dispelled by tracing the outline of the two bones as far forwards as their articulation; the finger, as it approaches this point, will at once detect the extraordinary prominence of the one, and the marked depression of the other, and so reveal the true nature of the accident.

The reduction is accomplished by pulling the shoulder outwards and backwards, while the knee rests against the dorsal portion of the spine, and the patient's elbow is carried across the chest, to afford greater relaxation to the muscles, and convert the humerus into a lever for acting more efficiently upon the acromion process. Retention is effected in the usual manner, with the additional precaution of preventing all motion of the inferior extremity of the scapula.

The dislocation *forwards and downwards*, beneath the coracoid process—the *infra-coracoid* form of the accident—is, like the preceding, very uncommon, a fall or blow upon the anterior surface of the shoulder being the cause by which it is ordinarily produced. The symptoms are characteristic. Besides the contusion and discoloration common to all such injuries, the acromion and coracoid processes are unusually prominent; the top of the scapula is strongly inclined downwards and forwards, and there is a marked depression in the natural situation of the clavicle, which, upon being traced with the finger, is found to be directed outwards and downwards, its extremity being actually lodged in the axilla. The arm may be moved in every direction, except upwards and inwards.

The reduction is easily effected. The chest being firmly fixed with a strong napkin, an assistant seizes the arm, and, converting it into a lever, uses it for pushing the scapula forcibly outwards and backwards, while the surgeon himself, grasping the clavicle, disengages it from its position beneath the coracoid process, and thus restores it to its natural situation. The retention is maintained by the usual apparatus.

Owing to the peculiar structure of the sterno-clavicular and acromio-clavicular joints, and the fact that their ligaments are always very badly ruptured in their dislocations, it is almost impossible to keep the parts in contact by any apparatus that can be used for the purpose. In view of this difficulty, I suggested, many years

ago, the propriety of connecting the articular extremities with silver wire introduced subcutaneously, and allowed to remain, if not permanently, at all events, until firm reunion is established. I have never had occasion to perform the operation, but successful cases of it have been reported by Dr. Cooper, of San Francisco, and Dr. Hodgen, of St. Louis.

Double dislocation of this bone has been observed, so far as I know, only in three instances. One of these has been reported by Porral, and is said to have occurred under the care of Gerdy, in the St. Louis Hospital, at Paris. The accident was caused by a fall from a third-story window, upon the upper and back part of the shoulder. The symptoms were well marked, the acromial end of the bone being luxated backwards and upwards, the sternal upwards and forwards. The treatment was by Desault's well-known, but now obsolete, apparatus, aided by large, graduated compresses over the affected joints. Under this dressing, the outer extremity of the clavicle soon became firmly united, but the other continued obstinately displaced.

The second case was reported by Morel-Lavellée, in 1859; and the third, in 1866, by Dr. N. L. North, of Brooklyn, his patient being a lad, fourteen years of age, who, in a fall from a stool, was thrown forcibly backwards, receiving the whole weight of his body upon the posterior part of the left shoulder. The displacement was complete at both joints.

The collar-bone is occasionally dislocated as the result of a *congenital* vice, as in a case which I saw in a child three months old, otherwise perfectly healthy and well formed. The displacement may be double; but in the instance under my care it was confined to the sterno-clavicular articulation, the clavicle projecting upwards and forwards in a very unseemly manner; and, although the reduction could readily be effected, it was impossible to keep the parts in place by any contrivance that could be devised for the purpose.

DISLOCATIONS OF THE STERNUM.

Dislocations of the sternum are extremely rare, and must necessarily be the result of extraordinary violence. Hence, they are nearly always complicated with serious lesion of the soft parts, and fracture of the ribs, spine, clavicle, or even of the sternum itself. The accident has hitherto been noticed only between the first and second pieces, the latter of which was always thrown in front of the other, no instance having yet been witnessed in which the displacement occurred in the opposite direction. In 10 cases collected by Malgaigne the dislocation was occasioned either by direct violence, as a blow or severe pressure, or by a fall from a considerable height, in which the spine was bent forcibly forwards. Of these cases, 5 terminated fatally from other injuries. Of 13 cases collected by Dr. John H. Brinton, of this city, including one by himself, 7 died, and 6 recovered. The immediate cause of death in 6 of the cases was fracture of the vertebral column. When the luxation is simple, no serious consequences are to be apprehended. The most reliable symptom is deformity, attended with pain, dyspnoea, and a creaking sound during respiration. The only accident with which it is liable to be confounded is fracture of the sternum. The reduction is not always practicable. When the overlapping is considerable, the best plan is to extend the patient's body over a few large bolsters and then push the second piece forcibly downwards and backwards.

A few cases have been recorded of dislocation of the ensiform cartilage from blows or falls upon the epigastrium. The accident is generally attended with pain in the stomach, dyspnoea, and obstinate vomiting. Reduction is effected by extension and pressure. In one instance an incision was made on one side of the depressed cartilage, through the peritoneum, and restoration accomplished by means of an elevator.

An example of congenital dislocation of the ensiform cartilage, caused by a fall during the fifth month of pregnancy, has been reported by Seger.

DISLOCATIONS OF THE SCAPULA.

Displacement of the scapula, apart from that of the acromio-clavicular articulation, may depend upon different causes. In general, it is produced by a relaxation of the fibres of the broad dorsal muscle, as it passes over the inferior angle of this bone. So far as my observation extends, the affection is most common in young girls, of a feeble, delicate organization, about the age of puberty. It is also occasionally met

with in boys, either from natural weakness, or from the violent, habitual exertion incident to certain avocations. When the affection exists in its worst form, the relaxation of the muscle may be so great as to permit the lower angle of the scapula to project in a very unseemly manner. In some instances both sides suffer simultaneously, and then the deformity is, of course, materially increased. Aching pain and weakness of the corresponding limb are ordinary concomitants of the complaint.

Occasionally the broad dorsal muscle, in consequence of a fall or blow, is forcibly wrenched from its connections with the scapula, and slips down beneath the inferior angle of the bone, which then forms a remarkable prominence immediately under the skin. The accident is easily recognized by the history of the case, by the contused condition of the soft parts, and by the loss of function in the superior extremity.

When the displacement is caused by a weak and relaxed condition of the dorsal muscle, the most reliable remedies are chalybeate tonics, friction with stimulating lotions, electricity, the cold shower-bath, and exercise in the open air. The arm should be supported in a sling, close to the side of the body, and the inferior angle of the scapula kept in place by means of a suitable pad secured around the trunk. In the traumatic form of the affection leeches and saturnine applications will be required, and the limb should be well raised and carried backwards, so as to afford complete relaxation to the injured muscle. Reattachment of the torn fibres should be aimed at, and for this reason the scapula should be maintained at rest for a long time, otherwise there will be a certainty of redisplacement. This occurrence, however, is of less importance than is generally supposed, as in time the parts, in great measure, if not completely, regain their original power.

Serious malposition of the scapula sometimes arises from paralysis of the rhomboid muscles, chiefly in young, anemic persons, of a scrofulous habit of body. Sedentary occupation and constrained posture powerfully predispose to its occurrence. Great deformity is apt to attend, the posterior border and inferior angle of the scapula being widely separated from the trunk, and standing out in bold relief. The treatment should consist of tonics and of various local means calculated to restore the functions of the affected muscles. Ammoniated lotions with the addition of strychnia, and the cold shower-bath, will be particularly serviceable.

DISLOCATIONS OF THE SPINE.

The vertebræ are so firmly connected to each other, and, excepting those of the neck, admit of such limited motion, that any injury directed against them is much more liable to break than to luxate them. Even in the cervical region, where the mobility is much greater than anywhere else among these bones, the accident is exceedingly uncommon, and it is fortunate that it is so, since it is almost always

Fig. 15.



Dislocation of the Spine between the Fourth and Fifth Cervical Vertebrae. The Cord was torn, the Paralysis being complete, and Death occurred in a few days.

Fig. 16.



Dislocation of the Spine seen Laterally.

fatal, owing to the violence inflicted upon the spinal cord, as shown in figs. 15 and 16, causing death not unfrequently in an instant, or, at furthest, within the first few days. When the patient survives the more immediate effects of the dislocation, he is very

apt to perish from inflammation of the spinal cord and its envelops, at a period varying from a few weeks to several months. Hence, whether the accident be considered with reference to its primary or secondary effects, the prognosis must be equally guarded, few persons, under any circumstances, recovering. In a dislocation of the sixth and seventh vertebræ, under the charge, many years ago, of Dr. Willard Parker and myself, death occurred in less than forty hours. The patient, a young circus-rider, met with the accident while engaged in tumbling in the pit; it was instantly followed by paralysis of all the extremities, and he gradually fell into a state of unconsciousness, which continued until he expired. The neck was stiff and painful, but there was no sign of displacement. On dissection, the articulating processes and bodies of the sixth and seventh cervical vertebræ were found to be completely detached from each other on the right side, but on the left the processes were still slightly adherent, while the connection between the bodies of the bones was perfect, although in a high state of tension. The two contiguous spinous processes were completely severed. There was no fracture. The spinal cord was sensibly compressed by the partial rotation of the seventh vertebra, and there was a slight effusion of blood in the spinal canal at the seat of the injury.

The above case is a good type of the effects which usually follow dislocations of the vertebræ. When the lesion occurs above the origin of the phrenic nerve, death is often instantaneous from stoppage of the respiration; if it be seated further down, the patient may live for some time, and eventually even recover, although such a contingency is an extremely remote one. The diagnosis is generally very obscure, as it is usually impossible to determine whether the accident is a dislocation or fracture, or a combination of both, while the treatment must, of necessity, be altogether empirical. The principal symptoms are paralysis of the extremities, tympanites, obstinate constipation, and retention of urine, which soon becomes loaded with phosphates, causing inflammation and ulceration of the bladder. If the patient survive any length of time, severe bedsores are liable to form upon the nates and other parts of the body, thus greatly increasing his suffering.

The most common cause of dislocation of the spine is external injury, as a blow, fall, or sudden wrench. An instance has been reported by La Salle in which the fifth and sixth cervical vertebræ were severed by a violent muscular effort, the patient, a maniac, dying in thirty-six hours. Occasionally the displacement is the result of ulceration of the vertebræ or the partial destruction of the ligaments.

As it respects the *reduction* of these dislocations, it is impossible to prescribe any regular or methodical course of procedure. Most practitioners, dreading interference on account of the danger of sudden compression of the spinal cord, and the consequent destruction of the patient, are in favor of allowing the parts to take care of themselves, hoping, with judicious management, for gradual recovery. Such a plan, it seems to me, is both wise and proper, at least in most cases, especially in those in which it is impossible to determine the diagnosis, or where the symptoms, although well marked, are not at all urgent, the patient having a tolerably good use of every part of the body save the one immediately concerned in the mischief. Under such circumstances, time and a "masterly inactivity" will often accomplish more than all the interference of the best surgeons. But there are exceptions to every rule, and, while most cases of this kind should be let alone, I would strongly advise an opposite course where, the symptoms being well marked, and the danger urgent, there is reason to believe that the patient will, if not relieved, speedily perish. In such an event any attempt to save him, however desperate, would be perfectly justifiable and proper. If we succeed, we obtain a victory; if we fail, we can but hasten an occurrence otherwise inevitable. A number of instances are upon record where the reduction was performed successfully. Thus, Dr. James R. Wood, not long ago, safely restored, by manipulation, a partial dislocation of the cervical vertebræ in a child; and Dr. Ayres, of Brooklyn, happily succeeded in a case of complete luxation of these bones ten days after the accident. The patient, a tall, muscular man, thirty years of age, had been violently struck on the back of the neck, the anterior portion of which was found to be remarkably convex from the blow, bulging forwards, and lifting up the larynx, as seen in fig. 17. The head, as the man sat in his chair, was thrown backwards and permanently fixed, the face being turned upwards. The posterior part of the neck exhibited a sharp, sudden angle at the junction of the fifth and sixth cervical vertebræ, around which the integument lay in

Fig. 17.



Bilateral Dislocation of the Fifth Cervical Vertebra.

fold. It was difficult to reach the bottom of this angle, even with strong pressure of the fingers, and, of course, the regular line formed by the projecting spinous processes was abruptly lost. The patient complained of intense pain at this part, and swallowed and breathed with difficulty; but there was not the slightest paralysis or diminution of sensation. The reduction was effected by means of the hands of the surgeon and of two assistants, applied to the chin and occiput in such a manner as to draw the head, at first, directly backwards, then upwards, and finally forwards, counter-extension being made with two folded sheets stretched obliquely across the shoulders. The system was completely relaxed by chloroform, and the bones were distinctly felt slipping into their natural situation. No unpleasant symptoms followed, and at the end of a week the man had the complete use of his head and neck.

A few cases of traumatic luxation of the *occipito-atloid* articulation have been reported, but, so far as I know, all, except one, and that was only a partial displacement, promptly proved fatal. The accident, until recently, was regarded by most writers as impossible, on account of the firm connections and restricted motions between the two bones.

A slow species of displacement occasionally occurs in this joint in children and youths, from scrofulous disease of the body and articular surfaces of the atlas, or of this bone and some of the other vertebræ. Several examples of it have come under my personal observation, and the subject has been ably discussed by Schupke and other German writers. The severe local suffering which it produces is to be allayed by rest and recumbency, leeches, blisters, and issues, especially those made with the actual cautery, while the constitution is to be improved by tonics and alterants, as quinine and iron, and the different preparations of iodine. When all disease is arrested, the patient may exercise in the open air, the neck and head being well supported by appropriate apparatus.

The *atlo-axoid* articulation, enjoying a much wider range of motion than the preceding, is more liable to luxation by external violence, the most common causes being blows upon the back part of the head, forcible torsion of the neck, tumbling, and standing on the head, eventuating in rupture of the ligament of the odontoid process, and the projection of this process against the spinal cord, inducing fatal compression. Lifting children up by the occiput and chin, in play, is capable of producing this accident, as is proved by the memorable case related by J. L. Petit, of a little boy, who, being thus raised up in the air, struggled so violently as to dislocate his neck, dying on the spot. The nature of the lesion may be suspected when, by a sudden twist, blow, or wrench, the head is turned to one side, and cannot be brought back to its natural position, the sterno-mastoid muscle being relaxed, and the part exquisitely painful. Unconsciousness usually succeeds the occurrence, and the patient, if not promptly relieved, soon expires. When the symptoms are urgent, an immediate attempt should be made to reduce the dislocation by inclining the head towards the side to which it is directed, in order to disengage the articular processes, a most hazardous step of the operation, and one which may instantly cause death by compression of the spinal cord. The processes being liberated, the head and neck are next brought to their natural position by rotating them gently in a direction contrary to that in which the luxation occurred.

Finally, there is occasionally a species of *subluxation* of the spine, consisting, as the name implies, in a partial displacement of the vertebræ, most frequently met with in the dorsal region. It may be caused by injury applied directly to the part, or, indirectly, through a fall upon the buttocks, in which these structures and the body are forcibly pushed towards each other, the violence of the shock being concentrated upon the ligaments, which, being thus forcibly rent asunder, leave a corresponding gap between the contiguous spinous processes. The accident is generally attended with severe concussion, and, occasionally, even with compression, of the

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spinal cord, thereby seriously endangering the patient's life. Sometimes there is partial paralysis, with retention of urine, and other unpleasant symptoms.

The treatment is by recumbency upon a soft hair mattress, with the application of leeches and medicated lotions to the seat of the injury, and such internal remedies as the particular exigencies of the case may seem to demand.

DISLOCATIONS OF THE RIBS AND COSTAL CARTILAGES.

Dislocations of the costo-vertebral articulations from external injury must be extremely rare, if, indeed, they are not altogether impossible. That this is true, any one may satisfy himself by inspecting the mode in which the ribs are connected to the vertebræ; the ligaments are both numerous and powerful, and, besides, each joint is protected by a great thickness of muscles, so that these bones, instead of yielding at their junctions, will be much more apt to give way in their continuity. The possibility, however, of the accident was not only admitted, but strenuously maintained, by many of the older surgeons, especially by Paré, Barbette, Platner, and Heister, in whose works may even be found an account of what they regarded as varieties of the lesion. But modern experience is entirely opposed to such a conclusion; in truth, there are altogether not more, perhaps, than half-a-dozen well-authenticated cases of dislocation of the costo-vertebral articulations upon record, and in nearly every one of these the injury was associated with fracture of the ribs, or of the ribs and spine; all proved fatal, and in none was it possible to make a satisfactory diagnosis during life. Such an accident must, therefore, be entirely beyond the resources of surgical art; even if it were possible to detect the nature of the affection, still it would be impracticable to remedy it, except upon general principles, any direct interference being out of the question.

Dislocation of the ribs from their cartilages, and of the latter from each other and from the sternum, is also a rare occurrence, although not as much so as displacement of the costo-vertebral articulations. I have myself seen several cases of the kind, one of which I attended, along with Dr. J. R. Pirtle, the patient being a man, sixty years old, who fell from a scaffold, a distance of ten feet, upon the stone steps below, his left shoulder and chest receiving the blow. Immediately after the accident there was violent dyspnoea, and the patient heard and felt, at every inspiration, something snap and jerk in his side, similar to the noise caused by pulling a finger-joint. Upon examination, this was found to proceed from a dislocation of the cartilages of the last three ribs from the sternum, the pieces playing to and fro during the movements of the chest. A fracture also existed in the left clavicle. In another instance the third and fourth ribs on the right side were severed from their cartilages. The remarkable case related by Sir Charles Bell, in his *Surgical Observations*, in which all the ribs were dislocated from their cartilages by the thorax being violently compressed between a wall and the beam of a mill, is familiar to every surgeon. Occasionally the costal cartilages are separated from each other.

Whatever form these costal dislocations may assume, their existence necessarily implies the infliction of severe injury, which cannot fail to tell badly upon the soft parts, both externally and within the chest, and to be followed, when it is not immediately fatal, by violent inflammation. Hence, besides the attention required by the local mischief, great care is demanded on account of the state of the system; in the first instance, to bring about reaction, and, secondly, to moderate the resulting excitement by appropriate antiphlogistics. The topical treatment is by bandage and compress, as in fracture of the ribs, the patient being compelled to breathe chiefly by the aid of the diaphragm.

DISLOCATIONS OF THE PELVIS.

Notwithstanding the great extent of the *sacro-iliac* surfaces, and the vast strength of the ligaments by which they are connected together, observation has demonstrated that they may occasionally be displaced along with the pubic symphysis, by external violence. Dr. Thomas Harris, of this city, met with a case of dislocation of these bones in a woman, thirty-five years of age, from a blow upon the sacrum inflicted by the husband's fist. In general, however, a much greater degree of force is necessary to produce such an accident, and hence there must almost always be more or less contusion of the soft parts, both externally and internally, extensive

2. SUPERIOR EXTREMITY.

DISLOCATIONS OF THE HAND.

Dislocations of the *thumb*, especially of its metacarpo-phalangeal joint, are, in many respects, so peculiar as to require separate consideration. Displacement of the phalanges backwards is by far the most common, the disposition of the articular surfaces, and the ligaments by which they are connected together, rendering luxation forwards or laterally extremely difficult.

In luxation of the metacarpo-phalangeal joint, the head of the first phalanx is thrown backwards, as seen in fig. 18, upon the dorsal surface of the metacarpal bone, generally by violence applied to the distal extremity or to the palmar surface of the thumb, while the joint is immoderately extended. The metacarpal bone being thus impelled by the weight of the body, and the proximal phalanx by the object struck, causes the ligaments to give way, and the articular extremities to glide past each other. It has been asserted that, when there is inordinate relaxation of the ligaments, mere muscular action is capable of producing the displacement, but the possibility of such an occurrence, especially in its complete form, is very questionable.



Fig. 18.
Dislocation of the Thumb on the Dorsum of the Metacarpus.

The dislocation is attended with great deformity, which is so peculiar that it may be regarded as characteristic. A large tumor, hard and circumscribed, and formed by the head of the first phalanx, exists upon the back of the joint, while another, equally hard, but not quite so distinct, is perceptible on the palmar aspect of the thumb, representing the distal extremity of the metacarpal bone; the thumb is sensibly shortened, and can generally neither be bent nor extended, its last phalanx, however, being usually flexed in consequence of the excessive tension of the tendon of the long flexor muscle. In most cases the head of the first phalanx will be found to rest upon the posterior and inner part of the metacarpal bone, and not, as is commonly supposed, altogether upon its dorsal surface, and it is owing to this fact that the thumb looks as if it were rotated a good deal inwards. The shortening of the member often amounts fully to one inch, thus giving it a stumpy, characteristic appearance.

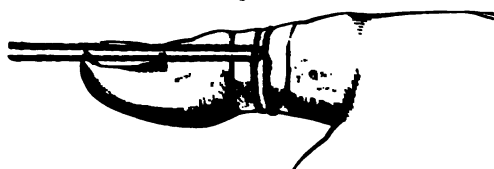
If a dissection be made of the affected parts, the ligaments will be found to be extensively ruptured, particularly the anterior; the extensor tendons are pushed backwards, and strongly stretched; and the external head of the short flexor muscle is torn in two, allowing the end of the metacarpal bone to pass completely through its fibres. The anterior ligament remains attached to the sesamoid bones and the first phalanx, the latter of which, as it is thrust backwards during the accident, carries both along with it, so as to deposit them, as it were, between its anterior surface and the contiguous surface of the metacarpal bone. In this way a partition is formed by these parts between the two bones, extending back some distance, and constituting, as Mr. Lawrie, by whom this arrangement has been so well described, justly remarks, a serious mechanical obstacle to replacement.

The reduction, as just stated, is generally difficult, and the means formerly employed to effect it were often so severe as to inflict the most dreadful injury, sometimes followed by extensive erysipelas and even mortification. Instances, in fact, were not wanting, though fortunately they were few, of the thumb being dragged off during violent and long-continued efforts at restoration. In many cases, again, all efforts of the kind proved unavailing, and the parts were obliged to be left in the condition into which the accident had thrown them. Desault, in order to accomplish his purpose, in difficult cases, suggested the idea of making an incision behind the extremity of the dislocated bone, and raising it out of its position by means of a suitable lever; and Evans went so far as to propose its removal altogether by excision. Charles Bell, on the other hand, attempted to remedy the evil by the subcutaneous section of one of the lateral ligaments, an operation which has frequently been performed successfully both in this country and in Europe. Sir Astley Cooper advises, after a fair trial of the ordinary means, an abandonment of the case, under

the idea that the patient will eventually have a useful thumb without reduction. I allude to these views simply because they serve to show the great difficulty which so often attends this dislocation, and the harsh expedients that have been suggested for overcoming it.

The most common method of effecting replacement is that by extension and counter-extension, employed upon the same principles as those which regulate their application in dislocation of other joints. It has always answered admirably in the

Fig. 19.



Clove-hitch Knot.

few cases of the accident that I have had to treat. The extension should be made by means of the clove-hitch, seen in fig. 19, secured over a wet cloth, or piece of buckskin, to protect the soft parts, and the counter-extension with a stout silk handkerchief, the fold resting in the palm of the hand, while the ends, crossed behind the wrist, and brought around the front of the forearm, are held by an

assistant. In this way the two forces may be applied with great effect, in a line with each other, and without the risk of unduly exciting the muscles concerned in the displacement. After they have been in operation for a short time, the thumb should be inclined inwards, in a semicircular direction, towards the ulnar margin of the hand, at the same time that the dislocated head is urged forwards and downwards by the surgeon's own thumb. Powerful extension may also be made by means of Charrière's forceps, fig. 20, and Dr. Levis's apparatus, the latter of which, delineated in

Fig. 20.



Charrière's Forceps.

fig. 21, is constructed upon the principle of the spatha, so much employed by the older surgeons for reducing dislocations of the shoulder. It consists of a flat, narrow piece of hard wood, ten inches in length, the proximal extremity of which is perforated on each side for the passage of two strong tapes, two feet long. Properly applied, as shown in fig. 22, the apparatus acts with great efficiency, affording a

Fig. 21.

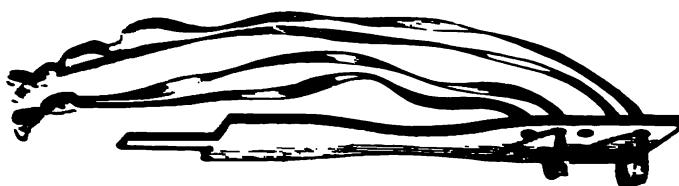


Fig. 22.



Dr. Levis's Apparatus for reducing Dislocations of the Thumb and Fingers.

powerful leverage, perfectly unyielding, and in every respect superior to the clove-hitch.

The reduction is sometimes easily effected by abduction and rotation of the thumb, the extension being maintained in the usual manner. If the effort fail, trial should next be made of the excellent method of Professor Crosby, of New Hampshire, originally practiced in 1828, and since recommended by Gerdy, of Paris. It simply

consists, as the adjoining cut, fig. 23, clearly exhibits, in pushing the phalanx back, until it stands perpendicularly on the metacarpal bone, when, by strong pressure directed against its base, from behind forwards, it is readily carried by flexion into its natural position. If this plan also fail, the only resource is the subcutaneous division of the tendon of the long flexor muscle, which is frequently, if not generally, the chief obstacle to replacement.

Fig. 23.



Dr. Crosby's Method of Reduction.

Fig. 24.



Forward Dislocation of the Thumb.

The annexed sketch, fig. 24, exhibits a plan of the dislocation of the head of the phalanx of the thumb forwards towards the palm of the hand. As already stated, it is an occurrence of great rarity. The symptoms are characteristic.

Dislocation of the *trapezio-metacarpal* joint may occur in four different directions, the end of the metacarpal bone being thrown off from the articular surface backwards, inwards, forwards, or outwards; the first two forms of the accident, however, are by far the most common, as will be apparent from an examination of the structure of the articulation and the arrangement of the muscles stretched along its anterior and outer surface.

Luxation backwards is always occasioned by external injury, as a blow or fall upon the dorsum of the thumb or the extremity of its metacarpal bone, by which the latter is suddenly and violently turned towards the palm. The signs of the accident are characteristic. A hard prominence is seen and felt upon the back of the trapezium, or at the posterior and radial surface of the hand, formed by the displaced head of the bone, the thumb is in a state of forced flexion, without the possibility of being extended, and the tendon of the extensor muscle is powerfully stretched, presenting itself as a firm, rigid cord behind the luxated bone. In order to effect reduction, two assistants are required; one to fix the hand by grasping the wrist, and another to pull the thumb with a clove-hitch. When the parts are thus drawn in opposite directions, the surgeon pushes the head of the bone forwards and downwards towards the palm, into its natural position. Sometimes the merest pressure from behind forwards and from above downwards is sufficient for the purpose. For some days the hand should be supported upon a broad splint, and means employed to moderate inflammation.

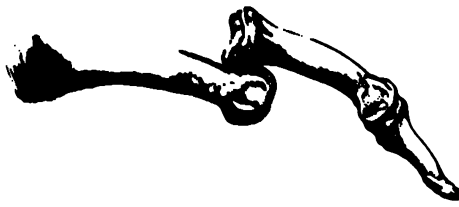
I have occasionally seen a partial dislocation of the metacarpal bone of the thumb backwards from inordinate relaxation of the ligaments. The occurrence is most common in weak, delicate women, and requires tonics, with the cold douche and a series of small blisters, for its relief.

In the luxation *inwards*, which is exceedingly infrequent, the metacarpal bone of the thumb is wedged in between the trapezium and the head of the metacarpal bone of the index-finger, so as to extend the thumb, and cause the trapezium to form a projection at the outer and back part of the palm. In the reduction the extension and counter-extension are conducted as in the preceding case, but they must be kept up a longer time, and, as the head of the bone approaches the trapezium, the thumb must be inclined towards the inner side of the hand, in order to relax the flexor muscles.

DISLOCATIONS OF THE FINGERS.

The phalangeal joints are susceptible of luxation backwards, fig. 25, an occurrence which can only be caused by severe force, and which is always so well characterized as to render any description of its signs unnecessary. The reduction is effected by extension and counter-extension, aided by pressure upon the head of

FIG. 25.



Dislocation of the Finger.

the displaced bone. The accident is extremely rare. In a case under my charge of a compound dislocation of the last joint of the right middle finger, in a stout, healthy man, the injury was produced by a fall, in which the end of the finger was struck violently against the ground. The distal phalanx lay upon the posterior surface of the middle one, a large wound existing in front. The reduction was easily effected, and the parts

well approximated by suture and collodion-plaster. I indulged the hope of a good cure. Presently, however, severe inflammation set in, terminating in necrosis of two bones, and I was obliged to amputate the finger immediately behind the joint.

Dislocation of the *metacarpophalangeal* joints, also a very uncommon accident, is usually displaced backwards, its extremity resting upon the posterior surface of the metacarpal bone. Of the luxation forwards I have seen but one case, and that was of many years' standing; the finger was considerably shortened, and could not be extended position, flexion being impracticable.

The luxation backwards is generally caused by severe blows upon the back of the hand, the extremity of the finger, while it is immovably bent. The case is

FIG. 26.



Dislocation of the Metacarpophalangeal Joint.

recognized by the existence of a hard tumor in the natural site of the knuckle of the hand, fig. 26, and by the shortened and fixed position of the finger, the extension of which is impracticable.

The reduction is usually not difficult. To effect it, extension is made upon the finger by means of a suitable band, fastened with a screw, and counter-extension upon the hand, while

the patient is seated, and the surgeon stands upon the heel of the dislocated finger, and presses down upon the head of the dislocated bone. The patient's fingers or Levis's fingers are used to assist in the reduction, as they are powerful levers, and the movements of the finger are easily controlled.

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ligaments, weakening their connections, and predisposing them to displacement under the application of comparatively slight force. The luxation is seldom complete.

Of the three bones above mentioned, the *magnum* is the most liable to dislocation; women are supposed to be more subject to it than men, owing to the greater mobility of the carpal joints, and the weaker state of the ligaments. The accident is caused by forced flexion of the wrist, from falls upon the back of the hand, wrenching the bone from its connections with the head of the corresponding metacarpal bone, and pushing it out behind, where it forms a hard, well-defined tumor, which increases when the wrist is bent, and diminishes when it is extended. The displacement is always incomplete, and is apt to be followed by severe tumefaction, which often temporarily obscures the diagnosis.

The reduction is effected by firm pressure, either with a tourniquet or some other suitable contrivance, applied to the bone from behind forwards, or in a direction contrary to that of the displacement, the hand being at the time in an extended state, in order to insure greater relaxation of the soft parts, and to increase the opening from which the bone has been ejected. The operation must be conducted with great gentleness, and the surgeon must not be disappointed if he do not succeed in his first attempt. In case there is much inflammation, leeches and fomentations will probably be required. To maintain the reduction, the hand must be placed in a straight position, upon two binder's board splints, well padded, and long enough to extend from the middle of the forearm to the ends of the fingers. If the tendency to displacement is very strong, as it usually is, it may be necessary to apply a compress directly to the luxated bone, with a view to a more direct concentration of the pressure. The apparatus must be worn for a long time, as the ligaments are very slow in uniting, but after the first fortnight it should occasionally be taken off, for the purpose of moving the wrist-joint, to prevent ankylosis.

Of dislocations of the *semilunar* bone, complete and uncomplicated, only a few examples are upon record. In a case which recently occurred in the practice of Professor Chisholm, of Baltimore, the accident was caused by a fall from a height of twenty-five feet upon the hand. The bone formed a hard tumor immediately beneath the skin, just above the last fold of the palmar surface of the wrist, on a line with the radius. The fingers were partially flexed, and could not be extended. A corresponding cavity existed on the back of the hand. As reduction was found to be impracticable, owing to the complete rotation of the bone, recourse was had to excision, an operation rendered unusually difficult on account of the very tense condition of the numerous ligamentous connections. An excellent recovery followed.

A singular case of compound luxation of this bone has been reported by Mougeot. A carpenter, in a fall from a height of thirty feet, upon the palm of the hand, received a wound half an inch in length near the wrist-joint, attended with an escape of the semilunar bone, which, as it adhered only by a few ligamentous threads, was readily removed. The wound speedily healed, and the man recovered with a good use of the hand.

Dislocation of the *cuneiform* bone is exceedingly uncommon; the accident can only occur when great force is applied, and must be treated upon the same general principles as the preceding.

The *pisiform* bone may be partially luxated by the action of the flexor muscle of the carpus, when its connections have been seriously weakened by disease of its ligaments. The occurrence is attended with some annoyance, and is difficult to remedy. When it is of sufficient importance to claim attention, the best plan is to place the hand in a slightly flexed position, in a wire case, extending from the middle of the forearm to the metacarpo-phalangeal joints, the carpal piece being so arranged as to form an obtuse angle with the other. A compress is applied to the lower and inner part of the wrist, in the situation of the displacement, and confined by adhesive strips and a bandage.

A case in which this bone was dislocated by an effort to lift a heavy weight, and drawn up the arm to a distance of nearly an inch by the flexor muscles of the carpus, is related by Mr. Erichsen.

DISLOCATIONS OF THE WRIST.

The possibility of dislocation of the wrist-joint, as an independent traumatic lesion, has been alternately admitted and denied by practitioners, from an early period of the profession down to the present moment. Dupuytren, after much patient attention to the subject, and the dissection of a number of cases simulating this accident, positively asserted that he never saw an instance of it, except as a result of organic disease of the articulation. He felt persuaded that the pretended cases which had been reported by various writers were simply examples of fracture of the inferior extremity of the radius, an accident which, as every one now knows, is of very frequent occurrence, and is generally attended with symptoms which closely imitate those of luxation of the wrist-joint. Observations, however, made since the time of the celebrated French surgeon, both in Europe and this country, indisputably prove that, although the lesion is exceedingly uncommon, its occurrence is not only possible, but that it has repeatedly been made the subject of clinical study.

The reason of the great infrequency of this accident is altogether of an anatomical character. From the manner in which the lower extremity of the radius is connected with the scaphoid, semilunar, and cuneiform bones, it is evident that any severe force applied to the hand, as in falls upon the palm or dorsum, must promptly be transmitted through the carpus to the radius rather than to the ulna, which can hardly be said to enter into the composition of the joint at all, except in so far as it affords some degree of lateral support. The consequence is that the spongy and delicate structure of the radius, receiving the brunt of the injury, usually gives way, either at the articulation or in the lower sixth of its extent, instead of allowing itself to be dislocated; fracture of the brittle osseous matter being generally much easier than the laceration of the strong ligaments which naturally tie the contiguous surfaces together.

The carpal bones may be displaced from the radius and ulna backwards and forwards; lateral luxation cannot occur without fracture of one of the styloid processes, and then only in an incomplete manner.

In the luxation *backwards*, the carpal bones are driven up behind the ends of the two bones of the forearm, which lie in front of the muscles of the thenar and hypothenar eminences; the consequence is that there is great deformity of the wrist-joint, its antero-posterior diameter being much increased, although its breadth is nearly natural. The forearm is somewhat shortened, the hand and fingers are forcibly flexed, and the ulna is thrown considerably forwards and inwards beyond the line of the carpus. The radius and ulna retain their normal length, and the prominence on the back of the joint is characteristically hard, convex, and transversely elongated.

In the dislocation *forwards*, fig. 27, from Erichsen, the symptoms just described are reversed, the carpal bones lying in front, and the end of the radius and ulna behind. The hand and fingers are powerfully extended, the distance between the elbow and wrist is sensibly diminished, although the two bones retain their proper length, and the styloid processes can be distinctly felt behind at the lateral aspect of the hand, with the articular groove which naturally separates them, and which is now occupied by the tightly stretched extensor tendons.

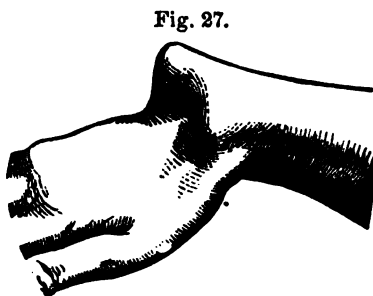


Fig. 27.

Dislocation of the Carpal Bones Forwards.

These two dislocations are liable to be mistaken for fracture of the lower extremity of the radius and ulna, although such an accident could hardly happen in the hands of a scientific surgeon, perfectly vigilant, and bent upon the discharge of his duties. The principal points of distinction are, that, in luxation, there is much more of a tumor than in fracture, that the tendons of the hand and fingers are more evidently affected, being either violently extended or flexed, that the radius and ulna retain their normal length, and that the bones are, as it were, firmly interlocked with each other. In fracture of the radius, or of the radius and ulna, on the contrary, the deformity is less marked in the antero-posterior diameter, the two bones, if both are broken, are sensibly shortened, there is much more mobility, and, upon bringing the

fragments in contact with each other, and then grasping the lower part of the forearm with one hand, while the patient's hand is moved with the other, crepitation may readily be elicited. Moreover, in luxation the styloid process of the ulna generally lies upon a plane somewhat anterior to that of the radius, whereas in fracture it is behind that bone.

The reduction of these two dislocations is sufficiently easy. All that is required, in order to accomplish it, is to extend the hand and counter-extend the forearm, immediately above its middle, while pressure is applied by means of the thumbs upon the displaced carpal bones in a direction opposite to that of the luxation. The limb, enveloped in a roller, is supported upon a light splint, stretched along its palmar aspect, and kept constantly wet with some evaporating lotion. In due time passive motion is instituted, to prevent ankylosis, so liable to occur after all injuries of this and other joints.

Congenital dislocations of the wrist have of late years attracted much attention, chiefly through the labors of Dupuytren, Cruveilhier, Guerin, R. W. Smith, and Dr. Robert Adams, of Dublin, who states that he met, within a few years, with not less than thirteen examples of it. The carpal bones may be thrown forwards or backwards, forming, in either case, a well-marked, characteristic, angular prominence. The lesion is attended with atrophy of the bones, ligaments, and muscles; the hand is generally useless, and the fingers are variously deformed, being usually wasted and crooked. I lately saw a well-marked case of lateral displacement of the wrist in a puny female infant, three weeks old, the hand presenting towards the radius. The treatment must be conducted upon general principles, although it will seldom be of much avail.

DISLOCATIONS OF THE RADIO-ULNAR JOINTS.

1. The *inferior radio-ulnar* joint is liable to displacement in two directions, the ulna being thrown backwards in the one case, and forwards in the other, beyond the line of the radius. The slightest anatomical inspection will serve to show, what experience has proved to be true, that the former luxation must be the more frequent of the two, though both are sufficiently rare as an uncomplicated lesion. As an accompaniment of fracture of the lower extremity of the radius, it is by no means uncommon; generally, however, only in a partial manner.

The dislocation *backwards* is usually the result of violence applied to the hand or forearm, during strong pronation, any sudden twist or wrench of the joint predisposing to its occurrence. The signs are characteristic. The hand is in a fixed state of pronation, and inclined a little towards its inner margin; the head of the ulna, directed obliquely across the radius, forms a distinct prominence above the level of the cuneiform bone; the fingers are slightly bent; the styloid process has lost its parallelism with the fifth metacarpal bone; and the inferior extremity of the forearm has an appearance of being unnaturally narrow, although, if some time has elapsed since the accident, this will probably be masked by the swelling. The reduction is effected by flexing the forearm at a right angle with the elbow, and then gradually but determinedly extending the hand, and rotating it outwards until it is brought into the supine position, when the bone will usually resume its natural relations.

The lower extremity of the ulna may be displaced *forwards* by a fall upon the wrist, by a violent wrench of the hand while in a state of supination, or by injury applied directly to the forearm. The accident is one of uncommon occurrence. The symptoms are the reverse of those in the preceding dislocation; that is, the ulna, lying across the anterior part of the radius, forms a remarkable projection just above the carpus, while the forearm and fingers, slightly bent, are powerfully supinated, and cannot be brought out of this position without restoring the joint to its normal condition. The reduction is effected in the same manner as in the luxation backwards, the limb, as the bone yields, being gradually but forcibly pronated.

It will be necessary after both these luxations, as the ligaments will be a long time in uniting, to keep the limb well bandaged, and supported by means of a padded splint, extending from near the elbow to the ends of the fingers. A firm compress is to be placed over the inner and fore part of the joint, the more thoroughly to protect it against a recurrence of the accident.

2. Dislocation of the *superior radio-ulnar* joint may occur in three different directions, the head of the radius being thrown from the sigmoid cavity of the ulna

Fig. 17.



Bilateral Dislocation of the Fifth Cervical Vertebra.

fold. It was difficult to reach the bottom of this angle, even with strong pressure of the fingers, and, of course, the regular line formed by the projecting spinous processes was abruptly lost. The patient complained of intense pain at this part, and swallowed and breathed with difficulty; but there was not the slightest paralysis or diminution of sensation. The reduction was effected by means of the hands of the surgeon and of two assistants, applied to the chin and occiput in such a manner as to draw the head, at first, directly backwards, then upwards, and finally forwards, counter-extension being made with two folded sheets stretched obliquely across the shoulders. The system was completely relaxed by chloroform, and the bones were distinctly felt slipping into their natural situation. No unpleasant symptoms followed, and at the end of a week the man had the complete use of his head and neck.

A few cases of traumatic luxation of the *occipito-atloid* articulation have been reported, but, so far as I know, all, except one, and that was only a partial displacement, promptly proved fatal. The accident, until recently, was regarded by most writers as impossible, on account of the firm connections and restricted motions between the two bones.

A slow species of displacement occasionally occurs in this joint in children and youths, from scrofulous disease of the body and articular surfaces of the atlas, or of this bone and some of the other vertebrae. Several examples of it have come under my personal observation, and the subject has been ably discussed by Schupke and other German writers. The severe local suffering which it produces is to be allayed by rest and recumbency, leeches, blisters, and issues, especially those made with the actual cautery, while the constitution is to be improved by tonics and alterants, as quinine and iron, and the different preparations of iodine. When all disease is arrested, the patient may exercise in the open air, the neck and head being well supported by appropriate apparatus.

The *atlo-axoid* articulation, enjoying a much wider range of motion than the preceding, is more liable to luxation by external violence, the most common causes being blows upon the back part of the head, forcible torsion of the neck, tumbling, and standing on the head, eventuating in rupture of the ligament of the odontoid process, and the projection of this process against the spinal cord, inducing fatal compression. Lifting children up by the occiput and chin, in play, is capable of producing this accident, as is proved by the memorable case related by J. L. Petit, of a little boy, who, being thus raised up in the air, struggled so violently as to dislocate his neck, dying on the spot. The nature of the lesion may be suspected when, by a sudden twist, blow, or wrench, the head is turned to one side, and cannot be brought back to its natural position, the sterno-mastoid muscle being relaxed, and the part exquisitely painful. Unconsciousness usually succeeds the occurrence, and the patient, if not promptly relieved, soon expires. When the symptoms are urgent, an immediate attempt should be made to reduce the dislocation by inclining the head towards the side to which it is directed, in order to disengage the articular processes, a most hazardous step of the operation, and one which may instantly cause death by compression of the spinal cord. The processes being liberated, the head and neck are next brought to their natural position by rotating them gently in a direction contrary to that in which the luxation occurred.

Finally, there is occasionally a species of *subluxation* of the spine, consisting, as the name implies, in a partial displacement of the vertebrae, most frequently met with in the dorsal region. It may be caused by injury applied directly to the part, or, indirectly, through a fall upon the buttocks, in which these structures and the body are forcibly pushed towards each other, the violence of the shock being concentrated upon the ligaments, which, being thus forcibly rent asunder, leave a corresponding gap between the contiguous spinous processes. The accident is generally attended with severe concussion, and, occasionally, even with compression, of the

spinal cord, thereby seriously endangering the patient's life. Sometimes there is partial paralysis, with retention of urine, and other unpleasant symptoms.

The treatment is by recumbency upon a soft hair mattress, with the application of leeches and medicated lotions to the seat of the injury, and such internal remedies as the particular exigencies of the case may seem to demand.

DISLOCATIONS OF THE RIBS AND COSTAL CARTILAGES.

Dislocations of the costo-vertebral articulations from external injury must be extremely rare, if, indeed, they are not altogether impossible. That this is true, any one may satisfy himself by inspecting the mode in which the ribs are connected to the vertebræ; the ligaments are both numerous and powerful, and, besides, each joint is protected by a great thickness of muscles, so that these bones, instead of yielding at their junctions, will be much more apt to give way in their continuity. The possibility, however, of the accident was not only admitted, but strenuously maintained, by many of the older surgeons, especially by Paré, Barbette, Platner, and Heister, in whose works may even be found an account of what they regarded as varieties of the lesion. But modern experience is entirely opposed to such a conclusion; in truth, there are altogether not more, perhaps, than half-a-dozen well-authenticated cases of dislocation of the costo-vertebral articulations upon record, and in nearly every one of these the injury was associated with fracture of the ribs, or of the ribs and spine; all proved fatal, and in none was it possible to make a satisfactory diagnosis during life. Such an accident must, therefore, be entirely beyond the resources of surgical art; even if it were possible to detect the nature of the affection, still it would be impracticable to remedy it, except upon general principles, any direct interference being out of the question.

Dislocation of the ribs from their cartilages, and of the latter from each other and from the sternum, is also a rare occurrence, although not as much so as displacement of the costo-vertebral articulations. I have myself seen several cases of the kind, one of which I attended, along with Dr. J. R. Pirtle, the patient being a man, sixty years old, who fell from a scaffold, a distance of ten feet, upon the stone steps below, his left shoulder and chest receiving the blow. Immediately after the accident there was violent dyspnoea, and the patient heard and felt, at every inspiration, something snap and jerk in his side, similar to the noise caused by pulling a finger-joint. Upon examination, this was found to proceed from a dislocation of the cartilages of the last three ribs from the sternum, the pieces playing to and fro during the movements of the chest. A fracture also existed in the left clavicle. In another instance the third and fourth ribs on the right side were severed from their cartilages. The remarkable case related by Sir Charles Bell, in his *Surgical Observations*, in which all the ribs were dislocated from their cartilages by the thorax being violently compressed between a wall and the beam of a mill, is familiar to every surgeon. Occasionally the costal cartilages are separated from each other.

Whatever form these costal dislocations may assume, their existence necessarily implies the infliction of severe injury, which cannot fail to tell badly upon the soft parts, both externally and within the chest, and to be followed, when it is not immediately fatal, by violent inflammation. Hence, besides the attention required by the local mischief, great care is demanded on account of the state of the system; in the first instance, to bring about reaction, and, secondly, to moderate the resulting excitement by appropriate antiphlogistics. The topical treatment is by bandage and compress, as in fracture of the ribs, the patient being compelled to breathe chiefly by the aid of the diaphragm.

DISLOCATIONS OF THE PELVIS.

Notwithstanding the great extent of the *sacro-iliac* surfaces, and the vast strength of the ligaments by which they are connected together, observation has demonstrated that they may occasionally be displaced along with the pubic symphysis, by external violence. Dr. Thomas Harris, of this city, met with a case of dislocation of these bones in a woman, thirty-five years of age, from a blow upon the sacrum inflicted by the husband's fist. In general, however, a much greater degree of force is necessary to produce such an accident, and hence there must almost always be more or less contusion of the soft parts, both externally and internally, extensive

ecchymosis, concussion of the spinal cord, injury of the sacral nerves, and fracture of some of the pelvic bones, thus seriously, if not fatally, complicating the case. Even when the patient survives the immediate shock of the accident, he is very liable to perish from the subsequent inflammatory and suppurative irritation, perhaps weeks after the primary effects have passed off.

Violent kicks or blows, and compression of the body between two hard and resisting objects, as a wall and a carriage, are the usual causes of this dislocation. The displaced bone is thrown backwards and upwards, forming a distinct prominence beneath the skin, easily perceptible by sight and touch, and attended with marked crepitation. The limb of the affected side is shortened and powerless, the crest of the ilium is raised beyond the natural level, the fold of the natis is flattened, the tuberosity of the ischium is higher than that on the sound side, and the ramus of the pubic bone lies somewhat posterior to the plane of its fellow. The parts are contused and exquisitely painful, and the patient is unable to lie upon his back, or to void his urine.

In the treatment of this luxation, the most important object, that upon which the safety of the patient mainly depends, is to prevent the ill effects of inflammation. To accomplish this, he must be kept perfectly at rest, and be subjected to the most strict antiphlogistic course, of which leeching, anodyne fomentations, and blisters form a most valuable constituent. When the inflammation has been measurably subdued, the parts should be covered with an ammoniac and mercurial plaster. The reduction, which is easily effected by pressure, is maintained by a compress and broad bandage, secured, if necessary, by thigh and shoulder straps. Great attention must be paid to cleanliness, as defecation will be both painful and inconvenient, and the urine must be regularly drawn off with the catheter. In a case mentioned by Hoin, the articular surfaces refused to come together until after the patient had begun to walk about, when the weight of the limb drew them gradually in place.

The *pubic symphysis* is sometimes wrenched open by external violence, as I have witnessed in two cases in persons whose bodies had been crushed between a railway car and the edge of the floor of the depot. The accident is generally fatal, not so much on account of the injury done to the joint and bones as of the violence sustained by the contents of the pelvic cavity. The treatment must be conducted upon the same principles as in dislocation of the sacro-iliac symphysis.

A separation of this joint occasionally occurs during utero-gestation, from softening of its fibro-cartilage, allowing the two bones to ride slightly upon each other, as in a case under my observation, not long ago, in a woman in her fifth pregnancy. The dislocation, beginning about a month before her confinement, was so great that she could not walk, or turn in bed, without great distress. The parts were exquisitely tender on pressure, and upwards of five weeks elapsed after parturition before they regained their healthy condition. Rest, recumbency, and leeches constitute the proper treatment, aided, when the patient is able to move about, by a belt with a pad upon the pubes.

The *coccyx* may be dislocated from the sacrum by external violence, as a fall, or kick, or by the pressure of the child's head in difficult parturition. The bone is usually thrown forwards or backwards. In a case reported by Dr. Roeser, it was displaced laterally, being torn away from the sacrum, and carried over towards the descending branch of the left ischium, where it formed a small but distinct tumor. The signs of the accident are, preternatural fixedness of the coccyx, with considerable shortening, difficulty in voiding the feces, tenesmus, and retention of urine. Reduction is effected by introducing the index and middle fingers of one hand into the rectum, while with the assistance of the fingers of the other, applied externally, the bone is pushed into its proper position. Rest, fomentations, and leeches will be required during the after-treatment. The bowels should not be moved for a number of days, and then only by means of saline cathartics and enemata, as all motion and straining would interfere with the reparative process and might even reproduce displacement.

2. SUPERIOR EXTREMITY.

DISLOCATIONS OF THE HAND.

Dislocations of the *thumb*, especially of its metacarpo-phalangeal joint, are, in many respects, so peculiar as to require separate consideration. Displacement of the phalanges backwards is by far the most common, the disposition of the articular surfaces, and the ligaments by which they are connected together, rendering luxation forwards or laterally extremely difficult.

In luxation of the metacarpo-phalangeal joint, the head of the first phalanx is thrown backwards, as seen in fig. 18, upon the dorsal surface of the metacarpal bone, generally by violence applied to the distal extremity or to the palmar surface of the thumb, while the joint is immoderately extended. The metacarpal bone being thus impelled by the weight of the body, and the proximal phalanx by the object struck, causes the ligaments to give way, and the articular extremities to glide past each other. It has been asserted that, when there is inordinate relaxation of the ligaments, mere muscular action is capable of producing the displacement, but the possibility of such an occurrence, especially in its complete form, is very questionable.



Fig. 18.

Dislocation of the Thumb on the Dorsum of the Metacarpus.

The dislocation is attended with great deformity, which is so peculiar that it may be regarded as characteristic. A large tumor, hard and circumscribed, and formed by the head of the first phalanx, exists upon the back of the joint, while another, equally hard, but not quite so distinct, is perceptible on the palmar aspect of the thumb, representing the distal extremity of the metacarpal bone; the thumb is sensibly shortened, and can generally neither be bent nor extended, its last phalanx, however, being usually flexed in consequence of the excessive tension of the tendon of the long flexor muscle. In most cases the head of the first phalanx will be found to rest upon the posterior and inner part of the metacarpal bone, and not, as is commonly supposed, altogether upon its dorsal surface, and it is owing to this fact that the thumb looks as if it were rotated a good deal inwards. The shortening of the member often amounts fully to one inch, thus giving it a stumpy, characteristic appearance.

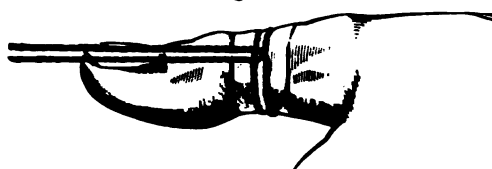
If a dissection be made of the affected parts, the ligaments will be found to be extensively ruptured, particularly the anterior; the extensor tendons are pushed backwards, and strongly stretched; and the external head of the short flexor muscle is torn in two, allowing the end of the metacarpal bone to pass completely through its fibres. The anterior ligament remains attached to the sesamoid bones and the first phalanx, the latter of which, as it is thrust backwards during the accident, carries both along with it, so as to deposit them, as it were, between its anterior surface and the contiguous surface of the metacarpal bone. In this way a partition is formed by these parts between the two bones, extending back some distance, and constituting, as Mr. Lawrie, by whom this arrangement has been so well described, justly remarks, a serious mechanical obstacle to replacement.

The reduction, as just stated, is generally difficult, and the means formerly employed to effect it were often so severe as to inflict the most dreadful injury, sometimes followed by extensive erysipelas and even mortification. Instances, in fact, were not wanting, though fortunately they were few, of the thumb being dragged off during violent and long-continued efforts at restoration. In many cases, again, all efforts of the kind proved unavailing, and the parts were obliged to be left in the condition into which the accident had thrown them. Desault, in order to accomplish his purpose, in difficult cases, suggested the idea of making an incision behind the extremity of the dislocated bone, and raising it out of its position by means of a suitable lever; and Evans went so far as to propose its removal altogether by excision. Charles Bell, on the other hand, attempted to remedy the evil by the subcutaneous section of one of the lateral ligaments, an operation which has frequently been performed successfully both in this country and in Europe. Sir Astley Cooper advises, after a fair trial of the ordinary means, an abandonment of the case, under

the idea that the patient will eventually have a useful thumb without reduction. I allude to these views simply because they serve to show the great difficulty which so often attends this dislocation, and the harsh expedients that have been suggested for overcoming it.

The most common method of effecting replacement is that by extension and counter-extension, employed upon the same principles as those which regulate their application in dislocation of other joints. It has always answered admirably in the

Fig. 19.



Clove-hitch Knot.

few cases of the accident that I have had to treat. The extension should be made by means of the clove-hitch, seen in fig. 19, secured over a wet cloth, or piece of buckskin, to protect the soft parts, and the counter-extension with a stout silk handkerchief, the fold resting in the palm of the hand, while the ends, crossed behind the wrist, and brought around the front of the forearm, are held by an

assistant. In this way the two forces may be applied with great effect, in a line with each other, and without the risk of unduly exciting the muscles concerned in the displacement. After they have been in operation for a short time, the thumb should be inclined inwards, in a semicircular direction, towards the ulnar margin of the hand, at the same time that the dislocated head is urged forwards and downwards by the surgeon's own thumb. Powerful extension may also be made by means of Charrière's forceps, fig. 20, and Dr. Levis's apparatus, the latter of which, delineated in

Fig. 20.



Charrière's Forceps.

fig. 21, is constructed upon the principle of the spatha, so much employed by the older surgeons for reducing dislocations of the shoulder. It consists of a flat, narrow piece of hard wood, ten inches in length, the proximal extremity of which is perforated on each side for the passage of two strong tapes, two feet long. Properly applied, as shown in fig. 22, the apparatus acts with great efficiency, affording a

Fig. 21.

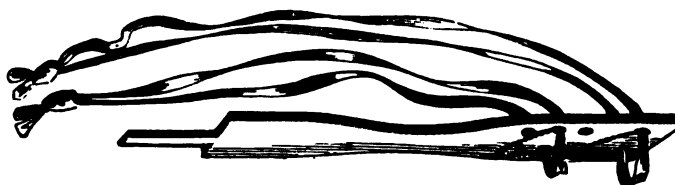
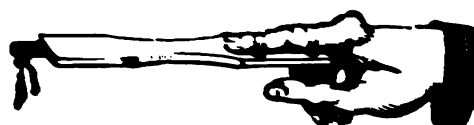


Fig. 22.



Dr. Levis's Apparatus for reducing Dislocations of the Thumb and Fingers.

powerful leverage, perfectly unyielding, and in every respect superior to the clove-hitch.

The reduction is sometimes easily effected by abduction and rotation of the thumb, the extension being maintained in the usual manner. If the effort fail, trial should next be made of the excellent method of Professor Crosby, of New Hampshire, originally practised in 1826, and since recommended by Gerdy, of Paris. It simply

consists, as the adjoining cut, fig. 23, clearly exhibits, in pushing the phalanx back, until it stands perpendicularly on the metacarpal bone, when, by strong pressure directed against its base, from behind forwards, it is readily carried by flexion into its natural position. If this plan also fail, the only resource is the subcutaneous division of the tendon of the long flexor muscle, which is frequently, if not generally, the chief obstacle to replacement.

Fig. 23.



Dr. Crosby's Method of Reduction.

Fig. 24.



Forward Dislocation of the Thumb.

The annexed sketch, fig. 24, exhibits a plan of the dislocation of the head of the phalanx of the thumb forwards towards the palm of the hand. As already stated, it is an occurrence of great rarity. The symptoms are characteristic.

Dislocation of the *trapezio-metacarpal* joint may occur in four different directions, the end of the metacarpal bone being thrown off from the articular surface backwards, inwards, forwards, or outwards; the first two forms of the accident, however, are by far the most common, as will be apparent from an examination of the structure of the articulation and the arrangement of the muscles stretched along its anterior and outer surface.

Luxation backwards is always occasioned by external injury, as a blow or fall upon the dorsum of the thumb or the extremity of its metacarpal bone, by which the latter is suddenly and violently turned towards the palm. The signs of the accident are characteristic. A hard prominence is seen and felt upon the back of the trapezium, or at the posterior and radial surface of the hand, formed by the displaced head of the bone, the thumb is in a state of forced flexion, without the possibility of being extended, and the tendon of the extensor muscle is powerfully stretched, presenting itself as a firm, rigid cord behind the luxated bone. In order to effect reduction, two assistants are required; one to fix the hand by grasping the wrist, and another to pull the thumb with a clove-hitch. When the parts are thus drawn in opposite directions, the surgeon pushes the head of the bone forwards and downwards towards the palm, into its natural position. Sometimes the merest pressure from behind forwards and from above downwards is sufficient for the purpose. For some days the hand should be supported upon a broad splint, and means employed to moderate inflammation.

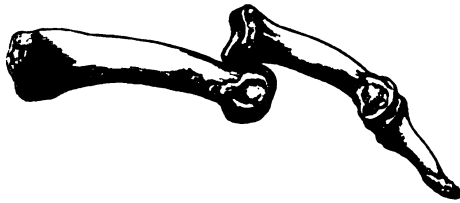
I have occasionally seen a partial dislocation of the metacarpal bone of the thumb backwards from inordinate relaxation of the ligaments. The occurrence is most common in weak, delicate women, and requires tonics, with the cold douche and a series of small blisters, for its relief.

In the luxation *inwards*, which is exceedingly infrequent, the metacarpal bone of the thumb is wedged in between the trapezium and the head of the metacarpal bone of the index-finger, so as to extend the thumb, and cause the trapezium to form a projection at the outer and back part of the palm. In the reduction the extension and counter-extension are conducted as in the preceding case, but they must be kept up a longer time, and, as the head of the bone approaches the trapezium, the thumb must be inclined towards the inner side of the hand, in order to relax the flexor muscles.

DISLOCATIONS OF THE FINGERS.

The phalangeal joints are susceptible of luxation backwards, fig. 25, an occurrence which can only be caused by severe force, and which is always so well characterized as to render any description of its signs unnecessary. The reduction is effected by extension and counter-extension, aided by pressure upon the head of

Fig. 25.



Dislocation of the Finger.

the displaced bone. The accident is extremely rare. In a case under my charge of a compound dislocation of the last joint of the right middle finger, in a stout, healthy man, the injury was produced by a fall, in which the end of the finger was struck violently against the ground. The distal phalanx lay upon the posterior surface of the middle one, a large wound existing in front. The reduction was easily effected, and the parts

being well approximated by suture and collodion-plaster, I indulged the hope of a good cure. Presently, however, severe inflammation set in, terminating in necrosis of the two bones, and I was obliged to amputate the finger immediately behind the joint.

In dislocation of the *metacarpo-phalangeal* joints, also a very uncommon accident, the phalanx is usually displaced backwards, its extremity resting upon the posterior surface of the metacarpal bone. Of the luxation forwards I have seen but one case, and that was of many years' standing; the finger was considerably shortened, and stood out in an extended position, flexion being impracticable.

Dislocation backwards is generally caused by severe blows upon the back of the hand, or the extremity of the finger, while it is immoderately bent. The case is

Fig. 26.



Dislocation of the Finger at the Metacarpo-phalangeal Joint.

recognized by the existence of a hard tumor in the natural site of the knuckle of the hand, fig. 26, and by the shortened and flexed condition of the finger, the extension of which is impracticable.

The reduction is usually not difficult. To effect it, extension is made upon the finger by means of a suitable lac, fastened with a sailor's noose, and counter-extension upon the hand, while

firm and steady pressure is made by the surgeon's thumb upon the head of the displaced bone. When these efforts fail, recourse is had to Charrière's forceps or Levis's spatha, both of which may generally be used with admirable effect, as they are powerful means not only for securing a firm hold, but for controlling the movements of the finger during the necessary manipulations.

Excepting by the bursting of a gun, or other severe violence, dislocation of the *carpo-metacarpal* joints must be regarded as impossible, owing to the intimate manner in which the four last bones of the metacarpus are connected with each other and with the bones of the second row of the carpus. Under such circumstances the injury is generally so great as to require amputation or excision, the latter operation always taking precedence when it is in our power to save any portion of the hand likely to be of service to the patient. Conservative surgery may do much in these cases to prevent mutilation by a careful use of the knife and pliers immediately after the occurrence of the accident, when the parts are tolerant of manipulation, and admit of being put in proper form for speedy reunion. A surgeon who cuts off a whole hand when the removal of a portion will suffice, has no just conceptions of his duty.

DISLOCATIONS OF THE CARPAL BONES.

From the firm connections and limited motions which characterize the carpal joints, it is evident that any displacement of them must be of very uncommon occurrence. Indeed, it was formerly asserted that such an accident was altogether impossible; a statement which has been contradicted by modern experience, which has not only established the fact, but elucidated the pathology and treatment of the lesion. The bones most liable to suffer in this way are the magnum, cuneiform, and pisiform, the occurrence being nearly always preceded by a relaxed condition of the

ligaments, weakening their connections, and predisposing them to displacement under the application of comparatively slight force. The luxation is seldom complete.

Of the three bones above mentioned, the *magnum* is the most liable to dislocation; women are supposed to be more subject to it than men, owing to the greater mobility of the carpal joints, and the weaker state of the ligaments. The accident is caused by forced flexion of the wrist, from falls upon the back of the hand, wrenching the bone from its connections with the head of the corresponding metacarpal bone, and pushing it out behind, where it forms a hard, well-defined tumor, which increases when the wrist is bent, and diminishes when it is extended. The displacement is always incomplete, and is apt to be followed by severe tumefaction, which often temporarily obscures the diagnosis.

The reduction is effected by firm pressure, either with a tourniquet or some other suitable contrivance, applied to the bone from behind forwards, or in a direction contrary to that of the displacement, the hand being at the time in an extended state, in order to insure greater relaxation of the soft parts, and to increase the opening from which the bone has been ejected. The operation must be conducted with great gentleness, and the surgeon must not be disappointed if he do not succeed in his first attempt. In case there is much inflammation, leeches and fomentations will probably be required. To maintain the reduction, the hand must be placed in a straight position, upon two binder's board splints, well padded, and long enough to extend from the middle of the forearm to the ends of the fingers. If the tendency to displacement is very strong, as it usually is, it may be necessary to apply a compress directly to the luxated bone, with a view to a more direct concentration of the pressure. The apparatus must be worn for a long time, as the ligaments are very slow in uniting, but after the first fortnight it should occasionally be taken off, for the purpose of moving the wrist-joint, to prevent ankylosis.

Of dislocations of the *semilunar* bone, complete and uncomplicated, only a few examples are upon record. In a case which recently occurred in the practice of Professor Chisholm, of Baltimore, the accident was caused by a fall from a height of twenty-five feet upon the hand. The bone formed a hard tumor immediately beneath the skin, just above the last fold of the palmar surface of the wrist, on a line with the radius. The fingers were partially flexed, and could not be extended. A corresponding cavity existed on the back of the hand. As reduction was found to be impracticable, owing to the complete rotation of the bone, recourse was had to excision, an operation rendered unusually difficult on account of the very tense condition of the numerous ligamentous connections. An excellent recovery followed.

A singular case of compound luxation of this bone has been reported by Mongeot. A carpenter, in a fall from a height of thirty feet, upon the palm of the hand, received a wound half an inch in length near the wrist-joint, attended with an escape of the *semilunar* bone, which, as it adhered only by a few ligamentous threads, was readily removed. The wound speedily healed, and the man recovered with a good use of the hand.

Dislocation of the *cuneiform* bone is exceedingly uncommon; the accident can only occur when great force is applied, and must be treated upon the same general principles as the preceding.

The *pisiform* bone may be partially luxated by the action of the flexor muscle of the carpus, when its connections have been seriously weakened by disease of its ligaments. The occurrence is attended with some annoyance, and is difficult to remedy. When it is of sufficient importance to claim attention, the best plan is to place the hand in a slightly flexed position, in a wire case, extending from the middle of the forearm to the metacarpo-phalangeal joints, the carpal piece being so arranged as to form an obtuse angle with the other. A compress is applied to the lower and inner part of the wrist, in the situation of the displacement, and confined by adhesive strips and a bandage.

A case in which this bone was dislocated by an effort to lift a heavy weight, and drawn up the arm to a distance of nearly an inch by the flexor muscles of the carpus, is related by Mr. Erichsen.

DISLOCATIONS OF THE WRIST.

The possibility of dislocation of the wrist-joint, as an independent traumatic lesion, has been alternately admitted and denied by practitioners, from an early period of the profession down to the present moment. Dupuytren, after much patient attention to the subject, and the dissection of a number of cases simulating this accident, positively asserted that he never saw an instance of it, except as a result of organic disease of the articulation. He felt persuaded that the pretended cases which had been reported by various writers were simply examples of fracture of the inferior extremity of the radius, an accident which, as every one now knows, is of very frequent occurrence, and is generally attended with symptoms which closely imitate those of luxation of the wrist-joint. Observations, however, made since the time of the celebrated French surgeon, both in Europe and this country, indisputably prove that, although the lesion is exceedingly uncommon, its occurrence is not only possible, but that it has repeatedly been made the subject of clinical study.

The reason of the great infrequency of this accident is altogether of an anatomical character. From the manner in which the lower extremity of the radius is connected with the scaphoid, semilunar, and cuneiform bones, it is evident that any severe force applied to the hand, as in falls upon the palm or dorsum, must promptly be transmitted through the carpus to the radius rather than to the ulna, which can hardly be said to enter into the composition of the joint at all, except in so far as it affords some degree of lateral support. The consequence is that the spongy and delicate structure of the radius, receiving the brunt of the injury, usually gives way, either at the articulation or in the lower sixth of its extent, instead of allowing itself to be dislocated; fracture of the brittle osseous matter being generally much easier than the laceration of the strong ligaments which naturally tie the contiguous surfaces together.

The carpal bones may be displaced from the radius and ulna backwards and forwards; lateral luxation cannot occur without fracture of one of the styloid processes, and then only in an incomplete manner.

In the luxation *backwards*, the carpal bones are driven up behind the ends of the two bones of the forearm, which lie in front of the muscles of the thenar and hypothenar eminences; the consequence is that there is great deformity of the wrist-joint, its antero-posterior diameter being much increased, although its breadth is nearly natural. The forearm is somewhat shortened, the hand and fingers are forcibly flexed, and the ulna is thrown considerably forwards and inwards beyond the line of the carpus. The radius and ulna retain their normal length, and the prominence on the back of the joint is characteristically hard, convex, and transversely elongated.

In the dislocation *forwards*, fig. 27, from Erichsen, the symptoms just described are reversed, the carpal bones lying in front, and the end of the radius and ulna behind.

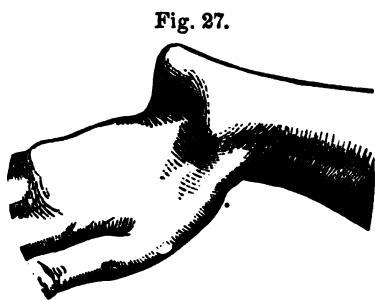


Fig. 27.

Dislocation of the Carpal Bones Forwards.

The hand and fingers are powerfully extended, the distance between the elbow and wrist is sensibly diminished, although the two bones retain their proper length, and the styloid processes can be distinctly felt behind at the lateral aspect of the hand, with the articular groove which naturally separates them, and which is now occupied by the tightly stretched extensor tendons.

These two dislocations are liable to be mistaken for fracture of the lower extremity of the radius and ulna, although such an accident could hardly happen in the hands of a scientific surgeon, perfectly vigilant, and bent upon the discharge of his duties. The principal points of distinction are, that, in luxation, there is much

more of a tumor than in fracture, that the tendons of the hand and fingers are more evidently affected, being either violently extended or flexed, that the radius and ulna retain their normal length, and that the bones are, as it were, firmly interlocked with each other. In fracture of the radius, or of the radius and ulna, on the contrary, the deformity is less marked in the antero-posterior diameter, the two bones, if both are broken, are sensibly shortened, there is much more mobility, and, upon bringing the

fragments in contact with each other, and then grasping the lower part of the forearm with one hand, while the patient's hand is moved with the other, crepitation may readily be elicited. Moreover, in luxation the styloid process of the ulna generally lies upon a plane somewhat anterior to that of the radius, whereas in fracture it is behind that bone.

The reduction of these two dislocations is sufficiently easy. All that is required, in order to accomplish it, is to extend the hand and counter-extend the forearm, immediately above its middle, while pressure is applied by means of the thumbs upon the displaced carpal bones in a direction opposite to that of the luxation. The limb, enveloped in a roller, is supported upon a light splint, stretched along its palmar aspect, and kept constantly wet with some evaporating lotion. In due time passive motion is instituted, to prevent ankylosis, so liable to occur after all injuries of this and other joints.

Congenital dislocations of the wrist have of late years attracted much attention, chiefly through the labors of Dupuytren, Cruveilhier, Guerin, R. W. Smith, and Dr. Robert Adams, of Dublin, who states that he met, within a few years, with not less than thirteen examples of it. The carpal bones may be thrown forwards or backwards, forming, in either case, a well-marked, characteristic, angular prominence. The lesion is attended with atrophy of the bones, ligaments, and muscles; the hand is generally useless, and the fingers are variously deformed, being usually wasted and crooked. I lately saw a well-marked case of lateral displacement of the wrist in a puny female infant, three weeks old, the hand presenting towards the radius. The treatment must be conducted upon general principles, although it will seldom be of much avail.

DISLOCATIONS OF THE RADIO-ULNAR JOINTS.

1. The *inferior radio-ulnar* joint is liable to displacement in two directions, the ulna being thrown backwards in the one case, and forwards in the other, beyond the line of the radius. The slightest anatomical inspection will serve to show, what experience has proved to be true, that the former luxation must be the more frequent of the two, though both are sufficiently rare as an uncomplicated lesion. As an accompaniment of fracture of the lower extremity of the radius, it is by no means uncommon; generally, however, only in a partial manner.

The dislocation *backwards* is usually the result of violence applied to the hand or forearm, during strong pronation, any sudden twist or wrench of the joint predisposing to its occurrence. The signs are characteristic. The hand is in a fixed state of pronation, and inclined a little towards its inner margin; the head of the ulna, directed obliquely across the radius, forms a distinct prominence above the level of the cuneiform bone; the fingers are slightly bent; the styloid process has lost its parallelism with the fifth metacarpal bone; and the inferior extremity of the forearm has an appearance of being unnaturally narrow, although, if some time has elapsed since the accident, this will probably be masked by the swelling. The reduction is effected by flexing the forearm at a right angle with the elbow, and then gradually but determinedly extending the hand, and rotating it outwards until it is brought into the supine position, when the bone will usually resume its natural relations.

The lower extremity of the ulna may be displaced *forwards* by a fall upon the wrist, by a violent wrench of the hand while in a state of supination, or by injury applied directly to the forearm. The accident is one of uncommon occurrence. The symptoms are the reverse of those in the preceding dislocation; that is, the ulna, lying across the anterior part of the radius, forms a remarkable projection just above the carpus, while the forearm and fingers, slightly bent, are powerfully supinated, and cannot be brought out of this position without restoring the joint to its normal condition. The reduction is effected in the same manner as in the luxation backwards, the limb, as the bone yields, being gradually but forcibly pronated.

It will be necessary after both these luxations, as the ligaments will be a long time in uniting, to keep the limb well bandaged, and supported by means of a padded splint, extending from near the elbow to the ends of the fingers. A firm compress is to be placed over the inner and fore part of the joint, the more thoroughly to protect it against a recurrence of the accident.

2. Dislocation of the *superior radio-ulnar* joint may occur in three different directions, the head of the radius being thrown from the sigmoid cavity of the ulna

forwards, backwards, and outwards, the frequency of the accident being in the order here stated, although some authorities contend that the displacement backwards is the most common. This I have not found to be the case in my own practice.

The chief causes of dislocation *forwards*, fig. 29, are falls upon the palm of the hand, in which, the forearm being powerfully supinated, the head of the radius receives the whole force of the blow, and is thrown against the coronoid process of the

Fig. 29.



Dislocation of the Head of the Radius Forwards.

ulna and the external condyle. The accident, which is most common in young subjects, may also be produced by direct injury to the upper extremity of the bone, acting from behind forwards. Dr. Krackowizer, of New York, has related a case in which the displacement was occasioned, as was supposed, by violence inflicted in turning the child in delivery.

The signs of this accident are quite characteristic. There is an obvious vacuity at the upper and outer part of the limb, and the head of the radius can be distinctly felt in its new situation, in front of the elbow, rolling about under the finger, upon rotating the lower extremity of the bone. The forearm, slightly flexed, is either pronated, or in a state midway between pronation and supination, and every attempt to bring it into a straight line or to a right angle with the elbow is unsuccessful. When an effort is made to bend the limb suddenly, the head of the radius will be found to strike against the lower and fore part of the humerus, refusing to advance; a circumstance characteristic of the nature of the accident. This dislocation is usually described as being accompanied by forced supination of the hand, but, in general, this is not the case.

The reduction is accomplished by applying extension to the hand and counter-extension to the middle of the arm, while the forearm, being semiflexed, in order to relax the two-headed flexor muscle, is forcibly supinated, at the same time that the head of the radius is pushed downwards and backwards, in the direction of its natural position. Owing to the extensive laceration of the soft parts, there is frequently great tendency to redisplacement after the reduction, with imperfect recovery of the functions of the joint.

The most common cause of luxation *backwards*, fig. 30, is violence applied to the hand when the forearm is in a state of pronation, and carried beyond the natural

Fig. 30.



Dislocation of the Head of the Radius Backwards.

line of the body. The accident is often associated with fracture of the internal condyle of the humerus.

The peculiar attitude of the limb in this luxation is almost characteristic of the nature of the injury. The forearm is semiflexed, and, together with the hand, in a fixed state of pronation; the fingers are also somewhat bent, and there is an evident void at the upper and outer part of the forearm, just below the elbow, while a short distance beyond this, over the

external condyle, by the side of the olecranon process, the prominence formed by the head of the displaced radius is distinctly perceptible, feeling hard and firm, and but faintly responding to any motions that may be impressed upon the lower extremity of the bone. Any attempt short of what is requisite to effect the reduction, to supinate the limb, to bring it into a straight line, or to flex it at a right angle with the arm, will be quite abortive, owing to the manner in which the radius hitches against the humerus.

Reduction is effected by making extension upon the hand and counter-extension upon the lower part of the arm in the line of the displacement, while the head of the radius is pressed from behind forwards, towards the lesser tubercle of the humerus, at the same time that the hand and forearm are gradually but forcibly supinated.

When the patient has not been relaxed by chloroform, the return of the bone is always indicated by a distinct snap.

Dislocation of the radius *outwards* is exceedingly uncommon. It occasionally exists, in an incomplete form, as a result chiefly of a relaxed condition of the annular ligament in persons of a feeble habit of body. Complete luxation outwards can only occur when there is a rupture of the upper extremity of the interosseous ligament, and hence the lesion is apt to be complicated with fracture of the humerus or ulna, and severe injury of the soft parts. A fall upon the palm of the hand, propelling the radius upwards and outwards, with the whole force of the leverage of this bone, is the most common cause of the accident.

The symptoms are generally unequivocal. The head of the radius, resting upon the epicondyle of the humerus, forms a distinct prominence at the outer part of the elbow, easily recognized by the finger; the bone is situated higher up than natural, the distance between it and the olecranon being materially increased; the forearm is in a state midway between pronation and supination, the latter of which is impossible; and the movements of flexion and extension are, of course, much impeded. Besides these signs, there is always a cord-like prominence along the front of the radius, as well as on the inside of the displaced head, formed by the tension of the external radial and long supinator muscles, which is gradually lost upon the outer and anterior surface of the limb. The reduction is effected by pushing the radius downwards and forwards, the forearm being bent at a right angle, and extension and counter-extension made in the usual manner.

The reduction of all these dislocations is generally very easy, but they are extremely liable to recur from the slightest causes, and it is, therefore, of great consequence, in the after-treatment, to guard against the accident by the use of the compress and bandage, aided by a suitable apparatus, to insure perfect quietude, until the ligamentous structures are reunited. Passive motion must not be neglected, otherwise ankylosis may ensue.

The superior radio-ulnar joint is liable to a species of *subluxation*, similar to that of the temporo-maxillary. I have seen a number of well-marked cases of it, in one of which it existed simultaneously on both sides; and in all it was manifestly dependent upon a relaxed condition of the annular ligament, allowing too great a latitude of motion between the head of the radius and the sigmoid cavity of the ulna. The subjects of this displacement are, for the most part, thin, weakly children of a strumous habit of body, and my experience is that females are more frequently affected than males. The movements of the joint are not materially impaired by the occurrence, unless it persists and gets worse, when the whole limb may become enfeebled in consequence. The cold douche, tincture of iodine, electricity, and a series of small blisters, with tonics to improve the general health, are the most suitable remedies.

Another form of dislocation liable to happen in this articulation is the *partial traumatic*, as it may be termed, chiefly met with in young children, from a sudden jerk, pull, or twist of the forearm, when the limb is in an overstretched state of pronation, the small size of the sigmoid cavity of the ulna at this period of life, and probably also a relaxed condition of the ligaments of the joint, favoring the occurrence. The accident is usually caused by the nurse in lifting the infant over the gutter, in dragging it rudely up to her side, or in her attempts to prevent it from falling. The head of the radius may be thrown either backwards or forwards, but the former displacement is by far the more common. The symptoms are generally well marked. A slight noise or snap is usually noticed at the moment of the accident; the child screams and is in great pain; the limb hangs motionless by the side; the forearm is slightly flexed, and the hand, strongly pronated, cannot be supinated without excessive suffering. There is ordinarily no swelling or deformity at the seat of the injury, not even after the lapse of several days.

The reduction, which occasionally occurs spontaneously during sleep, or during the manipulation necessary to detect the nature of the accident, is readily effected by extension and counter-extension at the hand and lower part of the arm, while an effort is made to force the forearm into a state of supination.

DISLOCATIONS OF THE ELBOW.

The dislocations of the elbow-joint form a subject of very deep interest, not only on account of the frequency of their occurrence, but because of their great liability to serious complications and the consequent difficulty of their diagnosis and treatment. I am satisfied, from no little observation, that there are no luxations which are so little understood, or so unscientifically managed. The principal reason of this is the want of correct knowledge of the structure of the elbow-joint, and of the complex arrangement of its osseous elements, with which few practitioners take the trouble to make themselves acquainted. The result is that cases of dislocation constantly occur which are mistaken for fracture, and which are, therefore, entirely neglected until it is too late to remedy them by means which, if timeously employed, would nearly always be sufficient to insure the reduction of the displaced bones, and the restoration of the bruised and lacerated tissues, with complete recovery of the functions of the articulation. It has been my lot to witness an unusually large number of such cases, generally at a period when nothing could be done for their relief.

The most common dislocation of the elbow is that in which both bones of the forearm are thrown upwards and backwards against the posterior surface of the humerus. Displacement forwards is exceedingly infrequent, as it can only occur, with very rare exceptions, when the accident is complicated with fracture of the olecranon process, whereby the ulna is permitted to glide in front of the joint, which it must do with great difficulty when its superior extremity remains intact. Lateral luxation of both bones of the forearm from the condyles of the humerus is also very uncommon, and is necessarily incomplete, owing to the great extent of the articular surfaces in this direction, and the number, size, and strength of the muscles and ligaments surrounding the joint. Of the displacements of the superior radio-ulnar articulation a sufficient account has already been given. The ulna alone is

sometimes luxated upwards, the olecranon forsaking the sigmoid fossa of the humerus, and applying itself against the posterior surface of that bone.

Fig. 31.



Dislocation of both Bones Backwards.

1. Dislocation of both bones of the forearm *backwards*, fig. 31, or, more correctly speaking, backwards and upwards, usually occurs from falls in which the person, instinctively stretching out the arm to protect the body, receives the whole shock upon the palm of the hand. The

two bones being thus impelled by the surface struck by the hand, and the humerus by the weight of the body coming in the opposite direction, the two forces explode at the elbow-joint, rupturing the ligaments, and driving the olecranon and head of the radius backwards and upwards. There can be no doubt that a contorted state of the forearm at the moment of the accident greatly promotes the luxation by increasing the strain. The accident sometimes occurs at a very early period of life, as in a case recently brought to my clinic, in a boy six years of age.

The signs of the dislocation are sufficiently obvious, presenting little variation in their character, unless the accident is conjoined with other injury. The limb is in a semiflexed state, and there is great deformity of the elbow. At the posterior part of the joint is the unnatural projection formed by the olecranon, and, in front, the still more conspicuous one formed by the condyles of the humerus, fig. 32, both usually perceptible by sight and touch, especially in lean subjects, and before the supervention of swelling. The forearm has generally a slightly twisted appearance, and occupies a position midway between pronation and supination, inclining, however, more to the latter than to the former; any attempt to flex or extend it is not only very painful, but in great measure impracticable. The fingers are somewhat bent, and the distance between the elbow and wrist is sensibly diminished, generally from an inch to an inch and a half, but only in front, for behind the limb retains its normal length. The muscles in front of the joint, especially the flexor and brachial, are

stretched like tense cords over the condyles of the humerus, while the tendon of the three-headed extensor is carried away from the bone behind, and stands out in bold relief, forming one of the most conspicuous signs of the accident, as seen in fig. 32. Although generally the forearm is semiflexed, and nearly immovable, yet occasionally it is almost straight, and can readily be bent and extended, not, however, without great pain.

Notwithstanding that the signs of this dislocation are usually characteristic, cases, nevertheless, occasionally occur where the diagnosis is painfully obscured. Two circumstances principally contribute to render it so. One is the inordinate swelling which so generally follows the accident, and which is often present in a high degree before the surgeon has an opportunity of examining the parts; the other, the existence of fracture of the bones composing the joint. When the humerus is broken off just above the condyles, the deformity closely simulates that produced by a dislocation backwards, the lower fragment, with the radius and ulna, being drawn in that direction, so as to give the back of the elbow a very prominent and distorted appearance, while the upper fragment will present itself quite conspicuously in front, under the flexor muscles. The points of distinction are that, in dislocation, the parts are fixed, and cannot be restored without a good deal of force, whereas, in fracture, they are easily moved and replaced, returning, however, to their unnatural situation the moment the efforts are discontinued. In dislocation, moreover, there is actual shortening of the anterior part of the forearm, but none in fracture; nor is there, in the former, any crepitation, which is so conspicuous in the latter. Fracture of the olecranon can always be distinguished by the elevation of the upper fragment, and the wide gap which separates it from the lower, and by the facility with which the surgeon can flex and extend the forearm. In fracture of the head of the radius there is no deformity of the posterior part of the elbow, and by grasping the bone with the thumb and finger above, as it is being rotated below, crepitation may easily be elicited, thus at once clearing up the diagnosis.

The reduction of this dislocation is extremely easy, if attended to immediately after its occurrence, but very difficult if it be neglected even for a short time. I have never been foiled in a recent case, but have met with many examples where every attempt proved unavailing after the third week, and sometimes, indeed, even by the end of the second. I am not prepared to assign any reason for this; to say why a displacement, that is always so easily rectified, if properly managed, in its earlier stages, should so soon become utterly irreducible, resisting and defying all the best directed efforts of the surgeon. It can hardly be supposed to be owing exclusively to inflammatory adhesions, for it is impossible that they could become either so extensive or so firm, in so short a time, as to produce such a result; but, whatever the true explanation may be, the fact remains, and the practical precept to be deduced from it is that all luxations of the elbow backwards should receive the earliest possible attention, their reducibility being in an inverse ratio to their duration.

But, although it is undoubtedly true that it is always extremely difficult, and sometimes utterly impossible, to reduce a dislocated elbow at the end even of two or three weeks after the occurrence of the accident, yet it would by no means be proper to abandon a case even if it were of three times that duration, inasmuch as a number of examples have been recorded which fully sanction such a course. I have myself met with several instances in which my efforts were rewarded, if not with complete success, certainly with very gratifying results, as it respected the functions of the joint, at the end of nearly two months. Sir Astley Cooper effected reduction at three months; Malgaigne, at three and a half; Blackman, Brainard, and Westmoreland, at five; Gerdy and Drake, at six. It is worthy of notice that the efforts, if long continued, may be followed by grave injury, as violent inflammation, supuration, and even gangrene. In a case treated by Velpeau, death was the consequence.

Fig. 32.



Dislocation of both Bones Backwards, showing the manner in which the Muscles are put on the Stretch.

Fig. 33.



Reduction with the Knee in the Bend of the Elbow.

The reduction may be effected in various ways. The one that is usually adopted is to make a fulcrum of the knee in the bend of the arm, as in fig. 33, the patient being seated upon a chair, and the surgeon standing by his side in front, with his foot resting upon a high stool or upon another chair. Extension being made by grasping the lower portion of the forearm, the limb is gradually brought over the knee so as to disengage more effectually the ulna and radius from the condyles of the humerus. This manœuvre is usually very promptly successful.

A method which I have often successfully employed, especially in cases in which some time had elapsed, but which has not, so far as I know, been described by any one else, is to place the heel instead of the knee in the bend of the arm, the patient lying down, and the surgeon carrying his leg across the chest, while extension is made by pulling the hand and wrist. This procedure affords the operator an opportunity of exerting his strength to great advantage. As the bones yield, the forearm is bent towards the chest over the fulcrum, furnished by the foot, a step which materially promotes the reduction. The force of the extension may be much increased by securing a stout lac around the limb, immediately above the

wrist, and throwing a noose over the neck and shoulder. Counter-pressure may also be usefully made by an assistant placing his hands against the shoulder of the affected side.

A third method of reduction, based upon the same principles as the preceding, is to bend the limb forcibly around a bedpost, which is thus made to act as a fulcrum, while the requisite extension is made by pulling the hand and wrist. This plan, however, although efficient enough, has the disadvantage of being both awkward and painful.

Finally, the reduction may often be readily effected by seating the patient upon a chair, and requesting two assistants to make extension and counter-extension, one grasping the wrist, the other the middle of the arm. The surgeon, standing behind the affected limb, then places his thumbs firmly upon the olecranon, and thus aids in pushing this process downwards and forwards into its natural position.

When unusual difficulty is anticipated, as when the patient is very muscular, or the luxation is several weeks old, the forearm may be bent forcibly backwards, beyond the straight line, when, with very slight extension and counter-extension, the parts will resume their natural relations. In a case in the hands of Dr. Waterman, of Boston, this method promptly succeeded after the failure of the more common procedures; and in one of my own, in a child six years old, a patient at the College Clinic, in which the dislocation was of five weeks' standing, I was equally fortunate, the reduction being effected in a few minutes. The coronoid process, in this method, being lifted out of the sigmoid fossa of the humerus, the muscles in front of the arm, by their tonic contraction, readily draw the bones of the forearm into their proper place.

When all these plans fail, the only resource is to employ the pulleys hooked to a noose fastened around the lower extremity of the forearm, and to a staple in the wall, floor, or bed. The counter-extending band is secured around the middle of the arm, and is either confided to two stout assistants, or fastened to some firm object behind the patient's head and shoulder. The patient should, of course, be recumbent, and fully anæsthetized. After the extending forces have been maintained for some time, the return of the bones will be promoted by steady pressure upon the olecranon. When these means fail, as will be extremely likely if the case is of longer standing than three weeks, it has been proposed to insert a narrow bistoury into the joint, so as to divide the resisting structures; but the operation, besides being dangerous, on

account of the proximity of the brachial artery and nerves, has disappointed the expectations of its advocates.

Reduction being effected, the limb, carefully bandaged, is supported in a light wire case, and kept constantly wet with evaporating lotions. If the inflammation run high, as it generally does after such an injury, leeches and even venesection may become necessary. In every case, however simple, the greatest vigilance must be employed to prevent ankylosis. Passive motion must, of course, receive early attention.

In decidedly chronic cases of this accident, but where there is still a good deal of motion, the patient may often obtain a very fair use of the joint by breaking the olecranon process by forcible flexion of the limb. I have pursued this plan with excellent results in several instances, and equally encouraging effects have attended it in the hands of Crosby, Mussey, and other surgeons.

2. Dislocation of both bones of the forearm *forwards* is an extremely rare event, which was formerly supposed to be altogether impossible without previous fracture of the olecranon, or extensive laceration of the soft parts. Modern observation, however, has shown the fallacy of this opinion, by adducing a number of unequivocal cases in which the displacement existed as a pure, uncomplicated affection. At least ten such examples are upon record, including one recently observed by Dr. Forbes, of this city, and another reported by Dr. R. P. Hunt, of Chicago. Of eight cases of forward luxation of both bones of the forearm collected by Streubel, six were unaccompanied by fracture of the olecranon. The manner in which the occurrence may happen is not well understood; but, from some experiments performed upon the dead subject, it would seem that if, while the forearm is powerfully flexed upon the arm, severe violence be applied directly to the olecranon and head of the radius, the articular surfaces of these bones may be thrown forwards from the condyles of the humerus with much greater facility than would at first sight appear possible. The accident is most common in young subjects under fifteen years of age, and must necessarily be attended with extensive rupture of the ligaments, if not also with severe contusion and laceration of the other soft parts.

The signs are sufficiently characteristic. When the ulna and radius are thrown completely forwards, in front of the condyles of the humerus, the forearm will necessarily be considerably shortened, whereas, when they retain their relation with the condyles, it will be elongated to the full extent of the length of the olecranon. The forearm, moreover, is slightly flexed, but by a little effort it may readily be extended, or even bent somewhat backwards. The skin and muscles in front of the joint are in a state of tension; the end of the humerus can easily be felt posteriorly, where it forms a large prominence, and there is a well-marked depression, a kind of vertical gutter, in the natural situation of the olecranon, bounded on each side by the margins of the trochlea.

Two methods of reduction may be employed for this dislocation; one consists in flexing the forearm at a right angle with the elbow, and making extension by pulling the hand and wrist, while the heel is applied as a fulcrum to the lower third of the arm, the patient being under the influence of chloroform. Or, instead of this, the extending and counter-extending forces may be applied to the hand and shoulder, the limb being in a straight position, and pressure made upon the ulna and radius by means of the thumbs. During the after-treatment, leeches and fomentations will probably be required, and the limb must be properly supported until the parts have united. Passive motion must be commenced at an early period.

3. *Lateral* dislocation of the elbow-joint, besides being extremely rare, can scarcely occur in any other than an incomplete form, and as a consequence of severe injury extensively implicating the soft parts. The most common cause of the accident is a fall upon the wrist or hand when the forearm is in a flexed and contorted state; and the displacement will be so much the more likely to happen if, the moment the extremity strikes the surface, the arm is forcibly impelled sidewardly. It may also be produced by violence acting directly upon the forearm and arm in opposite directions, as when the former is driven inwards and the latter outwards. In a case mentioned by J. L. Petit the accident was occasioned by the limb becoming entangled in the spokes of a wheel. The displacement may be inwards or outwards, and is often associated with partial dislocation backwards.

Fig. 34.

Lateral Dislocation
Inwards.

Fig. 35.

Lateral Dislocation
Outwards.

In the dislocation *inwards*, fig. 34, there is great deformity at the ulnar side of the elbow, produced by the olecranon and head of the radius, the latter hitching against the inner condyle, while the outer condyle presents an unusual prominence immediately beneath the integument at the external aspect of the joint; the forearm is partially bent, and somewhat supinated; and the muscles of the arm, both in front and behind, are dragged inwards by the displaced bones.

In the luxation *outwards*, fig. 35, the ulna rests upon the external condyle, while the inner condyle forms a sharp prominence on the inside of the elbow; the forearm is slightly bent and rigidly pronated; the motions of flexion and extension are much impeded; and the flexor and extensor muscles are in a painful state of tension. Both in this and in the inward displacement there is a remarkable increase in the breadth of the articulation, along with considerable flattening of its anterior surface, and a twisted condition of the forearm.

These luxations are easily reduced by extension and counter-extension, performed in the usual manner, and by coaptation by pressing

the bones in a direction opposite to that of their displacement. In general, the object may easily be attained by simply bending the elbow over the knee, as in the dislocation backwards. The after-treatment requires great care, both to prevent redispacement and ankylosis.

The only instance of complete lateral dislocation of the elbow with which I am acquainted is one recorded by Nélaton. It was observed in a man, sixty years of age, who was admitted for another disease, the accident having taken place twenty years previously, from a fall from a height of thirty feet. The elbow was much deformed and ankylosed.

4. Dislocation of the *ulna* alone directly *backwards* is an uncommon accident, and can scarcely be complete without fracture of the coronoid process. The signs are usually characteristic. The forearm and hand are slightly flexed, and inclined

Fig. 36.



Dislocation of the Ulna Backwards.

inwards as if they were twisted on their axis; the olecranon forms a prominent projection at the back part of the joint, as in fig. 36; and the head of the radius, although usually somewhat displaced, may be distinctly felt in its natural situation during the movements of flexion and extension, both of which, but particularly the latter, are very much restricted and painful. The accident generally arises

from severe falls upon the inner and upper part of the hand, suddenly and forcibly impelling the ulna upwards and backwards, away from the head of the radius; the coronoid process lodging in the sigmoid cavity of the humerus. Its most prominent features are the contorted state of the limb and the remarkable projection of the olecranon, which will always serve to distinguish it from other lesions. When the coronoid process is broken off, the posterior deformity will be unusually great, and, although it may be effaced by extension, yet the moment the arm is left to itself it returns.

The reduction is generally easily effected by bending the arm over the knee, and extending the hand and wrist. Coaptation may be aided, if necessary, by pressure upon the olecranon with the thumbs. When the accident is attended with fracture of the coronoid process, special retentive means will be necessary, of which the best

is a rectangular tin, felt, or gutta-percha case, the limb being properly bandaged, and a compress firmly bound over the olecranon.

5. Finally, the bones of the forearm are occasionally dislocated simultaneously in *opposite directions*, the ulna being thrown backwards behind the humerus, and the radius forwards upon a plane with the external condyle. The accident is uncommon, altogether not more than five or six cases having been reported. It is produced by falls from a considerable height upon the hand, impelling the two bones with great violence at a moment when the forearm is considerably flexed and forcibly twisted upon its axis. It is readily recognized by the singular form of the elbow, which is sensibly shortened transversely, but much increased in its antero-posterior diameter; by the great prominence at the back of the limb, formed by the olecranon process; and by the remarkable inward contortion of the forearm and hand, which are both slightly bent. On attempting to flex the limb, the head of the radius is found to hitch against the humerus, and to offer an insurmountable barrier to further progress. The reduction of the ulna is readily effected by placing the knee in the bend of the arm, and then pulling the hand and wrist; but that of the radius is more difficult, and will require, in addition, pressure upon the dislocated head outwards and backwards.

Compound dislocations of the elbow are serious lesions, liable to be followed by the worst results, both immediate and consecutive. Such is the extent of the articulating surfaces that any considerable exposure by wound is extremely liable to cause ulceration of the cartilages and caries or necrosis of the bones, requiring their eventual removal, or, what is worse, the sacrifice of the limb. The danger is materially increased when there is fracture with displacement, the end of one of the bones perhaps protruding in the form of a sharp spicule at the wound. Such cases will seldom do well if an attempt be made to replace and save the parts in the usual manner. The patient, if young and vigorous, may, it is true, occasionally progress favorably, but the chances are that the limb will, by and by, have to come off, or that life will be brought into imminent danger by the protracted suppuration, ulceration, and hectic irritation. When, therefore, the symptoms are at all unpromising—the joint being extensively opened, the muscles torn, and the bones seriously involved—the best plan, as a general rule, will be to amputate immediately, the moment reaction has occurred; or, under more auspicious, but still trying, circumstances, to excise the ends of the injured bones, placing them afterwards in such a position as to insure their speedy reunion, and, at the same time, in as good a one as possible for the future usefulness of the limb.

Congenital dislocation of the elbow is uncommon, and occurs only in a partial form. Most generally the displacement is limited to the head of the radius, which, forsaking the sigmoid cavity of the ulna, applies itself against the outer condyle. The movements of the elbow and forearm are restricted, but not annihilated; and, as the head of the luxated bone always becomes remarkably elongated as the patient advances in years, reduction is only practicable in infancy and early childhood.

DISLOCATIONS OF THE SHOULDER.

Dislocations of the shoulder-joint are of very common occurrence, being, as stated elsewhere, more frequent than all the other dislocations together, a circumstance which is easily accounted for by the shallow condition of the glenoid cavity of the scapula, and by the extraordinary latitude of motion peculiar to this articulation. Moreover, there is in many persons, females and children especially, a remarkable tendency to relaxation of the ligaments and muscles of the shoulder-joint, which thus powerfully predisposes to luxation, the slightest accident being, when the parts are in this condition, often sufficient to produce it.

Experience has shown that dislocations of the shoulder are not nearly as frequent in women as in men; simply, however, I imagine, for the reason that they are much less exposed than the other sex to the various exciting causes of these lesions.

Age exerts a material influence upon their production. The statistics of Malgaigne and others show that children under fifteen years rarely suffer from them. I have myself not seen a solitary example before the age of twelve; but Dr. John Ashhurst and Dr. John H. Packard, of this city, have each met with one in a child under three years; and Mr. Flower, of London, refers to one in an infant fourteen days old, caused by a violent wrench of the arm. From fifteen to twenty-five the

accident is also comparatively rare, but from this period on it becomes more common, and from forty to sixty it reaches its maximum. After sixty there is a marked decline in its frequency, and few cases are met with after seventy.

The nomenclature of these accidents has been much encumbered by distinctions and refinements, which, so far from simplifying the subject, only serve to embarrass it. There are, in fact, only three principal dislocations of the shoulder; all the rest, concerning which so much has been written, are mere varieties, hardly entitled to separate consideration, as they differ only in the degree of the displacement. These dislocations are the axillary, thoracic, and subspinous. In the first, as the name implies, the head of the humerus is situated in the axilla, under the glenoid cavity; in the second, below the clavicle, on the anterior and lateral aspect of the chest; and in the third, on the posterior surface of the scapula, either immediately below the acromion process, or on the dorsum of the bone a short distance below the spine. To these may be added, as varieties of the first two luxations, those cases in which the head of the bone has been found in the subscapular fossa, and upon the anterior part of the neck of the scapula, below the coracoid process. The nomenclature here suggested, besides indicating the situation of the luxated bone, is in strict conformity with that of the dislocations of the hip-joint.

1. The *axillary dislocation*, by far the most frequent of all, is usually occasioned by violence applied to the elbow or hand, the limb being elevated, and widely removed

from the body. It may also be produced, when the arm is in this position, by a fall or blow upon the shoulder, acting directly upon the head of the humerus. I have met with five cases in which the accident was caused by muscular contraction. In four of the cases the luxation occurred in an attack of epilepsy, and in the other simply from raising the arm inadvertently above the level of the head. Dr. Garrison, of Illinois, met with a case in which it was produced in a fit of sneezing. However induced, the head of the humerus will be found to be in the axilla, just beneath the glenoid cavity, lying upon the inferior border of the scapula, fig. 37, between the subscapular muscle and the long head of the triceps. The axillary vessels and nerves are somewhat compressed, the capsular ligament is largely opened below, and the articular muscles are nearly always more or less lacerated, if not partially separated from their attachments. The supraspinatus and deltoid muscles, particularly the former, are violently stretched and spasmodically contracted; the broad dorsal and great pectoral, on the contrary, are usually somewhat relaxed.



Fig. 37.

Dislocation of the Humerus into the Axilla.

Instead of lying below the glenoid cavity of the scapula, the head of the bone not unfrequently rests in the upper part of the armpit, immediately below and a little to the inner side of the coracoid process, under cover of the coraco-brachial and pectoral muscles. Mr. Flower, who has carefully investigated shoulder-joint dislocations, finds that this position of the displaced bone is more common than any other. The accident, originally described by Malgaigne as the subcoracoid luxation, is, however, strictly speaking, only a variety of the axillary, properly so called, the head of the bone being held in this peculiar situation by the action of the muscles which are attached to it.

The *symptoms* are, inordinate prominence of the acromion, as exhibited in fig. 38, which is much more sharp and distinct than natural, with a well-marked depression just below this process; flattening of the shoulder, and unusual fullness of the axilla, caused by the presence of the displaced bone, which, on motion of the limb, can easily be felt rolling about between the thumb and fingers, especially in lean subjects. The height of the axilla is at least an inch to an inch and a half greater than on the sound side. The elbow projects considerably from the trunk in consequence of the tension of the deltoid muscle, the forearm is slightly bent, the arm is perceptibly lengthened, the fingers are benumbed from compression of the axillary nerves, and the whole extremity, stiff and powerless, is generally somewhat supinated, although not

necessarily so, as I have repeatedly seen it inclined in the opposite direction. Flexion of the forearm, also, is not an invariable occurrence; generally it is said to be so, but a number of cases have come under my observation where the patient was able to extend and bend it at pleasure. When the biceps and triceps are put considerably upon the stretch, as when the head of the bone is thrown unusually far inwards, the limb often presents a singularly twisted appearance.

In Malgaigne's subcoracoid luxation, in which the humerus lies immediately below and to the inner side of the coracoid process, the symptoms are similar to those present in the axillary form of the accident, properly so called; but the head of the bone is not so distinctly outlined, and cannot always, especially in very muscular subjects, be perceived, unless the elbow is considerably elevated and rotated upon its axis. The arm is usually a little longer than natural, but occasionally it is actually shorter.

Although the signs of this dislocation are generally well marked, there are few accidents which are so liable to be mistaken, and no pains should, therefore, be spared to establish a correct diagnosis. The most reliable phenomena are, the flattening of the deltoid muscle, the prominence of the acromion process, the fullness and increased height of the axilla, and the peculiar projection of the elbow, which cannot be brought in contact with the side without strongly inclining the body outwards. The latter occurrence may be regarded as especially valuable, as there is no other lesion that simulates it. Another sign, also of great certainty, as originally shown by Dr. Dugas, of Georgia, is, that neither the patient nor the surgeon can bring the elbow in contact with the front of the chest if there be a dislocation.

2. The *thoracic dislocation*, the subclavicular of the French surgeons, is comparatively rare, and is usually caused by violence applied directly to the head of the humerus, or to the elbow, when the arm is elevated, and carried behind the central line of the body. The bone is thrust to the sternal side of the coracoid process, immediately below the clavicle, resting against the second and third ribs, under cover of the pectoral muscles, as exhibited in fig. 39. The anterior and inner parts of the capsular ligament are extensively ruptured, and there is usually considerable injury sustained by the adjoining muscles, especially the subscapular, the infraspinatus, and the small teres, which are often severed from their attachments. In a case described by Malgaigne, the head of the bone lay immediately beneath the integument, in the interval between the deltoid and pectoral muscles.

The *symptoms* of this dislocation are usually well marked. The acromion juts out with great distinctness, the depression beneath it being much more conspicuous than in the axillary variety of the accident, from the manner in which the deltoid muscle is drawn over towards the chest; and the head of the humerus is generally easily detected just below the clavicle, forming a hard pro-

Fig. 38.



Dislocation of the Humerus into the Axilla.

Fig. 39.



Dislocation of the Humerus Forwards upon the Chest.

minence which readily obeys the movements of the limb. The elbow stands off widely from the body, in a backward direction, and the arm is commonly shortened from half an inch to an inch. The pain is less severe than in dislocation downwards, as there is no compression of the axillary plexus, but the impairment of the functions of the joint is greater. The most important diagnostic marks are, the peculiar attitude of the limb, the extraordinary prominence of the acromion, and the position of the head of the bone just below the clavicle, where it can generally be both felt and seen.

3. The *subspinous* dislocation, fig. 40, is so uncommon that it may very properly be considered as one of the rare forms of injury of the shoulder-joint. It is generally produced by a fall upon the elbow or hand, the

Fig. 40.



Dislocation of the Humerus Backwards upon the Scapula.

limb being at the moment raised, and stretched out in advance of the body, a movement which has the effect of depressing slightly the head of the humerus, and of throwing it backwards upon the posterior surface of the scapula. The inferior part of the capsular ligament is extensively opened, and the articular muscles are not only stretched, but often severely lacerated, the subscapular being generally detached from the lesser tuberosity of the humerus.

The head of the bone in this dislocation most generally rests immediately beneath the posterior angle of the acromion, upon the back of the neck of the scapula, or upon the posterior border of the glenoid cavity. In rare cases only does it lie upon the dorsum of the scapula below the spine, as the term *subspinous* would seem to imply.

The *symptoms* are usually well marked. The rotundity of the shoulder is diminished, but not completely effaced, the acromion is abnormally distinct, and the head of the humerus may be both seen and felt in

its new position, at the posterior part of the shoulder, below the spine of the scapula. The arm is considerably shorter than natural, and the forearm, strongly rotated inwards, is bent obliquely across the chest. The axilla is deprived of its fullness, and, upon making firm pressure there, before there is any considerable swelling, the finger can be made to sink into the glenoid cavity. Supination of the limb is entirely impossible, and all attempts at motion are productive of an unusual degree of pain and distress, owing to the manner in which the head of the humerus is impacted in its new position.

General Diagnosis.—Although the diagnosis of dislocations of the shoulder-joint is usually sufficiently clear, cases occasionally occur where it is quite the reverse. There are several accidents with which they are liable to be confounded, and from which it is of great importance they should be correctly distinguished. Thus, mere contusion of the deltoid muscle, or a sprain of the articulation, sometimes simulates to a very perplexing extent the symptoms of luxation, by causing more or less obliquity of position of the arm, with inability to raise it; and the inexperienced practitioner is, consequently, liable to treat the case with improper severity, employing, perhaps, violent extension and counter-extension, when nothing but the most simple treatment is necessary. In general, however, the diagnosis is easily enough determined by a careful inspection of the affected joint. When there is no displacement, the head of the bone will, of course, be found to occupy its natural position, the shoulder to preserve its rotundity, and the arm to retain its natural length. Motion, too, will be found to be perfect if the patient be examined under the influence of chloroform.

Great perplexity will be likely to arise when there is a fracture of the acromion, the neck of the scapula, or of the superior extremity of the humerus; hence, whenever such an occurrence is suspected, the surgeon cannot possibly be too much upon the alert. In each of these accidents there are three circumstances which, if carefully considered, will always serve to prevent mistake. These are, preternatural mobility of the parts, crepitation, and facility of reduction, followed by an immediate recurrence of all the symptoms the moment the surgeon relinquishes his hold upon the limb. In dislocation, the head of the humerus is firmly fixed in its new situation, and is, consequently, moved with difficulty; there is complete absence of crepitation,

or, if there be any noise of this kind, it is very faint, and entirely different from that which is caused by rubbing together the ends of a fracture; and, lastly, the restoration of the displaced bone can be effected only after much effort, generally, indeed, not without energetic extension and counter-extension. Moreover, the reduction being once effected, the articular surfaces usually retain their natural relations, having no disposition again to separate.

In fracture of the acromion, the outer extremity of the bone is drawn down by the action of the deltoid muscle, giving the shoulder a sunken appearance, and the arm is sensibly elongated and supported by the patient's hand. Restoration is readily effected by raising the elbow, but, upon abandoning it, there is an immediate reproduction of all the former symptoms, thus at once deciding the nature of the injury.

In fracture of the neck of the scapula, a very rare accident, the acromion retains its natural position, but is uncommonly prominent; the arm is elongated, and crepitation is easily elicited by raising the elbow, which will also have the effect of restoring the form of the joint.

The signs of fracture of the head and neck of the humerus are generally characteristic. The extremity of the bone, constituting the upper fragment, retains its natural position, while the rough, angular end of the shaft projects upwards and inwards into the axilla, being drawn thither by the pectoral and dorsal muscles. There is no displacement of the acromion, the shoulder is less flattened than in luxation, and the arm, instead of being elongated or of the natural length, is materially shortened.

Treatment.—Various methods may be employed for effecting the reduction of these different forms of dislocation; but the best of all, especially in the axillary, is to place a fulcrum in the armpit, upon the luxated bone, while extension is made upon the forearm, just above the wrist. The most efficient fulcrum for this purpose is the heel of the surgeon, divested of its boot, he and the patient lying in opposite direc-

FIG. 41.



Reduction with the Heel in the Axilla.

tions upon a bed or table; and the efficiency of the operation will be materially increased, if, after the extension has been maintained for a little while, the limb is gradually brought forwards over the body, so as to raise the bone upwards and outwards to a level with the glenoid cavity. I sometimes find that I can reduce the dislocation more promptly and with less effort by sitting between the patient's limbs, with my own leg carried obliquely over the trunk, as this affords a much more powerful leverage than in the ordinary procedure. When unusual resistance is encountered, the extension should be aided by means of a stout fillet, secured around the lower part of the arm by the clove-hitch, and thrown across the surgeon's neck and shoulder.

Dr. Garms, instead of placing the patient upon his back, makes him lie upon the abdomen. Two towels are fastened around the arm, one just above the elbow, the other a short distance below the shoulder. The latter is then given in charge of an assistant, standing on the affected side, to draw the arm laterally, while the operator, sitting on the floor, seizes the former, and, applying the heel in the usual manner, makes extension downwards and backwards. The operation is particularly

Fig. 42.



Reduction with the Knee in the Axilla.

applicable to the axillary form of the accident, and is so simple as not to require the aid of chloroform.

Dr. Samuel Logan, of New Orleans, practises a method of reducing this dislocation, in which the surgeon, placing his legs nearly at a right angle with the patient's body, with a slight inclination upwards, plants the heel of one foot in the axilla, against the ribs, so as to press a little crosswise, while the base of the great toe of the other foot rests against the acromion process. The trunk and shoulder being thus firmly steadied, the necessary traction is made upon the forearm, as in the ordinary method.

Occasionally the reduction is readily accomplished by making a fulcrum of the knee, as in fig. 42, the patient sitting up, and the surgeon supporting his foot upon the edge of his chair, or upon a stool. The operation is particularly applicable to dislocations in delicate females, and in old, emaciated subjects. It is performed by inserting the knee as high as possible in the axilla, and then, the top of the shoulder being thoroughly steadied

with the hand, carrying the elbow forcibly downwards and inwards towards the side of the body. This procedure is characterized by great simplicity, but wants the efficiency of the preceding.

A very simple method of reducing this dislocation, represented in fig. 43, was practised by Brunus in the thirteenth century, and by White, Mothe, Bell, Thompson, and others in the last. Revived by Rust, Kluge, Firz, and Malgaigne, it has

Fig. 43.



Reduction by the Perpendicular Method.

been known to succeed when other expedients have failed. In the original plan the patient lies upon his back, while the surgeon, standing behind him, raises the limb perpendicularly above the head, the shoulder being firmly fixed with one hand upon the acromion process, and the requisite extension made with the other, by grasping the arm above the elbow. The efficiency of this method will be greatly increased if, as suggested by Mr. George Lowe, the patient be placed in the sitting posture against a couch, sofa, or bedstead, the scapula steadied with the foot, the extension made at the wrist, and the humerus rotated upon its axis as the head of the bone approaches the glenoid cavity.

Mr. Kirby, of Dublin, was in the habit of reducing this luxation by a method somewhat more complicated than any of the preceding, but not less efficient. The patient being seated upon the floor, a stout fillet was secured around the lower part of the arm, and confided to an assistant, while another assistant, also seated upon the floor upon the opposite side, steadied the scapula by encircling the chest with his arms, his fingers being interlocked in the axilla. When these preliminaries w

arranged, the assistants carried each one leg behind and the other in front of the patient, so as to rest the soles against each other. The limb being now elevated nearly to a right angle with the body, the extension was made in a slow and gradual manner, while the head of the bone was urged upwards towards the glenoid cavity, the elbow being at the same time raised and brought towards the side.

I have never had occasion to employ the pulleys in recent dislocations of the shoulder, and can hardly imagine that they could be necessary even in very stout, muscular subjects, as any surgeon may with a little patience and skill effect reduction by the methods now pointed out, with the aid of chloroform. Should a resort to the pulleys, however, be demanded, they must be employed with great care, lest harm should befall the axillary vessels; for the very fact that restoration cannot be accomplished by manual effort is an evidence of probable complication, and should be sufficient at least to put the surgeon on the alert. The operation is performed during the recumbency of the patient, or as he sits on his chair, as seen in fig. 44. The shoulder is firmly fixed by means of a long fold of muslin, the arm being passed through a hole in the centre, and its ends held by assistants, or fastened to a staple in the wall. The extending hand is tied around the lower part of the arm just above the elbow, and secured to the pulleys, which are then put in motion, the forces being applied transversely, and the head of the bone, as it approaches its socket, being lifted up by the hands in the axilla.

The reduction in the thoracic variety is easily effected by placing the heel in the axilla, so as to fix the scapula, and making the extension obliquely downwards and a little backwards, in the line of the displacement. The patient should lie upon the sound side, and as the head of the bone approaches the glenoid cavity it should be urged on by the pressure of the foot, at the same time that the arm is brought over to the body, very much as in the dislocation downwards. The chief impediments to the reduction are the two spinate muscles along with the deltoid.

The reduction of the subspinous dislocation is effected by making extension and counter-extension in the usual way, and urging the head of the bone from behind forwards by means of the hand, until it can be perceived in the axilla, when the restoration is completed by bringing the arm gently downwards and backwards, first into a line with the body, and then a little in advance of it. The principal obstacles to the replacement are the supraspinatus, subscapular, large teres, and great pectoral muscles, which are generally powerfully stretched.

Reduction by Manipulation.—The different forms of dislocation now described may all be reduced by mere manipulation, especially in recent cases, although I believe that the heel in the axilla is generally preferable to every other. In many instances simple torsion of the limb, particularly by rotation from without inwards, as recommended by Lacour, is quite sufficient for the purpose. The operation is performed by grasping the lower part of the forearm, and then turning the limb upon its axis, which has the effect of throwing the head of the humerus backwards and outwards, towards the glenoid cavity, when all that is necessary to induce it to slip into its proper position is to bring the limb on a line with the trunk. In this manner, I reduced in a few seconds, in 1869, after the failure of other means, an axillary dislocation of nearly three months' standing.

In this country attention was first prominently directed to this subject by Professor Henry H. Smith. The manipulation, as practised by him, consists, first, in elevating the arm and flexing the forearm; secondly, in rotating the head of the humerus upwards, outwards, and backwards, as far as possible, by using the forearm

Fig. 44.



Extension with the Pulleys.

as a lever; and, lastly, in rotating the head of the bone strongly upwards and inwards by a reverse movement, while the elbow is brought to the side, the palm of the hand looking down, instead of up, as in the second stage of the proceeding.

When the head of the bone is thrown forwards upon the chest, it must, as a preliminary step, be forced down into the axilla, by carrying the elbow as far back as possible, and then elevating it, when, rotation being properly executed, it will readily slip into the glenoid cavity. In the posterior luxation, the same object is attained simply by raising the arm and carrying it strongly forwards.

The method of reducing dislocations of this joint by manipulation was warmly advocated, and rules laid down for its performance, by Sir Philip Crampton, as early as 1833, in a series of papers on the subject in the Dublin Medical Journal. In the luxation downwards he made gentle extension at the wrist, to secure a long lever, and then slowly raised the limb to nearly a horizontal position, so as to relax the flexor and extensor muscles. He then suddenly pushed the arm upwards and a little forwards, towards the patient's face, or, in other words, rotated it inwards with the hand turned prone, and at the same instant forced the trunk suddenly backwards with the left hand placed below the axilla.

In the luxation forwards, "the surgeon," says Crampton, "should place his left arm, extended horizontally, immediately below the walls of the axilla, between the dislocated arm and the chest, and then, grasping the wrist in his right hand, he should draw the arm forcibly across the patient's body."

In recent cases mere pressure with the fingers, as originally practised by Avicenna, afterwards by Desault, and lately again by Richet and Pitha, is often sufficient to effect the object even without the aid of an anæsthetic, particularly in the axillary variety of the accident. The patient being seated upon a chair, the surgeon, standing at his side, places one hand upon the acromion process of the scapula, and the other, with the fingers semiflexed, in the armpit upon the head of the humerus, while an assistant gently raises the affected arm, or the surgeon does this himself by letting the elbow rest upon his forearm. By pressure, steadily and persistently directed, the bone is gradually lifted over the rim of the glenoid cavity, its return being frequently accompanied by a distinct snap. The object will be greatly facilitated if the muscles of the arm and shoulder are perfectly relaxed, and if, as the head of the humerus approaches the glenoid cavity, the arm be slightly rotated upon its axis.

Complicated Dislocations.—Luxation of the shoulder is sometimes complicated with fracture of the acromion, the neck of the scapula, or the superior extremity of the humerus. When this is the case, the rule is to reduce the dislocation, and then to set the fracture, the limb being put up temporarily in splints, as it will thus afford a better leverage for the management of the displaced bone.

Compound dislocations of the shoulder-joint are rare in civil practice. When the head of the humerus is forced through the soft parts, no time should be lost in restoring it to its natural position, provided it has not sustained any serious detriment, in which case it should promptly be excised, so as to afford the patient a better chance of recovery.

Laceration of the axillary artery, followed by a diffused aneurism, sometimes complicates this accident. The prominent symptoms are, cessation of pulsation at the wrist, and the sudden formation of a large tumor in the axilla. The proper plan is to reduce the dislocation, and then to ligate the artery above and below the seat of rupture. In a case related by Mr. Robert Adams, in which this was done, the patient made an excellent recovery. Dr. J. C. Warren was compelled to tie this vessel on account of an enormous aneurism, the result of injury inflicted by the surgeon's boot in an effort to effect replacement in a recent dislocation.

Anomalous Dislocations.—Malgaigne, in 1849, described, under the name of *supracoracoid*, a luxation, at that time considered as unique, in a man, sixty-eight years of age, in which the head of the humerus was thrown forwards and upwards, above the coraco-acromial ligament, in contact with the inner border of the acromion. It rested upon the coracoid process, touched the lower surface of the clavicle, and formed a prominent projection immediately beneath the deltoid muscle. The arm was slightly shorter than natural. In a more recent case, under the care of Mr. T. Holmes, in a man, fifty years of age, who had fallen from a great height upon a heap of stones, the head of the bone had escaped from the glenoid cavity of the scapula, and lay upon the stump of the coracoid process, broken in the accident. It extended as high up as the clavicle and coraco-acromial ligament, and, having passed through

the fibres of the deltoid muscle, was covered merely by the skin. The long tendon of the biceps retained its attachment to the scapula, but was pushed to the outer side of the head of the humerus, which was twisted somewhat upon its axis. An example, apparently of a similar kind, has been recorded by Mr. Prescott Hewett.

Dr. Willard Parker, in 1852, met with a case of luxation of the shoulder-joint, in which the head of the humerus was thrown into the *subscapular fossa*. The accident occurred while the patient, a young man, twenty years of age, was at work in a woollen factory, his right arm being caught between the belt and drum, and violently rotated outwards, while the machinery was in rapid motion. When the limb was liberated, it was found lying diagonally across the body, in a state of strong, fixed pronation; the rotundity of the shoulder was lost; and the head of the bone could be distinctly felt beneath the scapula. The reduction was effected by carrying the arm outwards at a right angle with the body, and then pulling the hand and wrist, so as to force the humerus into the axilla, whence it was afterwards easily raised into its proper situation.

Larrey has described a preparation, in which the head of the humerus had penetrated the chest, through the third intercostal space, so as to form a tumor within its cavity. The accident was produced by a fall upon the elbow, separated at the moment from the side of the body.

In a case reported by Laugier, the bone was turned directly forwards, resting against the outer margin of the coracoid process. The great tuberosity corresponded to the glenoid cavity, and the limb had a remarkably twisted appearance.

The reduction in these anomalous dislocations is effected upon the same principles as in the more ordinary forms of the accident. As there is usually extensive laceration of the soft parts, the operation is generally a very easy one, although it may be very difficult to keep the head of the bone in place, especially when the accident is associated with fracture of the coracoid process or the glenoid cavity of the scapula.

Double Dislocations.—Finally, there is occasionally a simultaneous dislocation of both shoulder-joints. Such an accident, however, of which interesting cases have been reported by W. H. Van Buren, Geddings, Cowper, T. W. Grosvenor, and others, is exceedingly uncommon. The head of each bone is generally forced down into the axilla, or one occupies this situation and the other the chest beneath the pectoral muscles. The dislocation, which is sometimes complicated with fracture of the scapula and humerus, is usually caused by a fall, in which the person stretches out both hands to save himself from injury. In a case treated by Ballingall, the accident occurred during an epileptic fit; and in another, recorded by Nathan Smith, in an attack of puerperal convulsions.

The reduction in the double dislocation is effected upon the same general principles as in the single variety. In Smith's case, just referred to, replacement was effected at the end of seven months. In a case recorded by Fischer, the patient, a stout, athletic man, restored the parts by his own efforts. Seating himself upon a high bench, he seized, simultaneously with both hands, a transverse beam above his head, and, throwing himself suddenly and forcibly from his seat, both bones instantly slipped into the glenoid cavities with a crackling noise. In Van Buren's case, the man died in five hours after the accident, from injury of the skull and brain.

After-treatment.—The after-treatment of dislocations of the shoulder requires special attention. In the first place, it is highly important to guard against a recurrence of the accident, which is so liable to happen after all injuries of this kind, especially after luxation into the axilla. Generally, all that is necessary for this purpose is to support the elbow, forearm, and hand for some time in a sling close to the side of the body; or, if the patient be restive, the arm may be secured to the trunk, over a small pad, by six or eight turns of a bandage. Full elevation, abduction, and rotation of the limb should not be permitted for five or six weeks, or until there is reason to believe that the capsular ligament and muscles have been in great degree repaired. The resulting inflammation is treated upon general principles. Passive motion, the cold douche, and liniments will be required to prevent ankylosis.

Dislocations of the shoulder are particularly liable to be followed, despite the best directed efforts of the surgeon, by atrophy of the deltoid muscle and by more or less permanent rigidity of the articulation. To counteract these occurrences, passive motion should be instituted as early as possible after the receipt of the injury, and perseveringly continued until the parts are completely restored to their normal con-

dition. When, as occasionally happens, the rigidity is dependent upon contraction of the neighboring muscles, especially the great pectoral and broad dorsal, it may be promptly overcome by the free subcutaneous division of the resisting fibres with the tenotome. The atrophy of the deltoid may sometimes be relieved by electricity and by frictions with veratria liniment.

One of the most disagreeable and perplexing occurrences after the reduction of a dislocation of the shoulder is the difficulty of keeping the parts in their natural relations. This circumstance may be due to several causes, the most frequent of which are, fracture of the margins of the glenoid cavity, and the rupture of some of the muscles of the joint, in consequence of which the head of the humerus, the moment it is left to itself, falls away from the scapula into some abnormal situation, generally down into the axilla, by the mere force of the weight of the arm. Such an event is always very annoying, inasmuch as it is apt to induce the belief, on the part of the patient and his friends, that the reduction was not perfectly effected. The best remedies are rest and proper support of the affected parts, followed, in due time, by passive motion and other means for combating rigidity and ankylosis.

Accidents.—Dislocations of the shoulder are sometimes followed by paralysis of the deltoid muscle, from injury done to the circumflex nerve by the head of the humerus. Occasionally the axillary plexus suffers very seriously, and then the paralysis may be much more extensive, involving, perhaps, the whole arm, as in two cases reported by Professor Dugas. When the lesion is slight, it may get well spontaneously, or with the aid of stimulating liniments, veratria ointment, and counter-irritation, especially vesication; but in its more severe forms, as when it depends upon contusion and partial disorganization of the nerves, it often proves very refractory, and may even be incurable.

Another unpleasant effect which now and then succeeds dislocations of the shoulder, is œdema of the corresponding extremity, arising from the pressure of the head of the humerus upon the axillary veins and lymphatics; this, however, rarely lasts beyond a few days, and generally disappears spontaneously or under very simple means.

A sudden development of emphysema, first noticed by Desault, is sometimes met with after this accident, and is well calculated to create unpleasant apprehensions in the mind of the attendant. It is evidently caused by a wound of the chest, from fracture of a rib, penetrating the pleura and lung, as is proved by the fact that the starting-point of the air is always under the pectoral muscle, from which it rapidly spreads to the axilla and to other parts. It may readily be distinguished from an extravasation of blood, consequent upon rupture of the axillary artery, by its elasticity, by the continuance of the pulse at the wrist, by the natural appearance of the skin, and by the production of a crackling noise when the part is pressed with the finger. Astringent lotions and gentle compression are the proper remedies.

Finally, the accident is sometimes attended with rupture of the axillary artery, leading to copious infiltration of blood, or, when the lesion affects only the inner tunics of the vessel, to the formation of a false aneurism. In either case, of the latter of which a remarkable one has been recorded by Nélaton, the proper treatment, after the reduction of the luxation, would be the ligation of the subclavian. Bérard met with an instance of subcoracoid dislocation in which there was no pulsation at the wrist after the accident; several of the fingers were attacked with gangrene, and the patient died. The internal coats of the axillary artery were torn across in their entire circumference, and the outer one greatly stretched.

Old Dislocations.—Old dislocations of the shoulder are often brought under the notice of the surgeon, and the question, therefore, arises, at what period after their occurrence should he refrain from an attempt at reduction? Upon this subject I do not think it possible to lay down any definite rules. I have myself been foiled at the end of the sixth week, and I have known the same thing to happen to other practitioners of great skill and experience. On the other hand, I succeeded in one case at the seventy-second day, and in another at the expiration of the third month. Physick succeeded in a number of instances after two and three months; and examples of from four to seven months' standing have been reported by McKenzie and Jameson, of Baltimore, Dorsey and Gibson, of this city, and by other American surgeons. Dr. Nathan Smith effected reduction in one case nearly one year after the occurrence of the accident. Keppell is said to have succeeded at the end of fourteen months, and Dieffenbach at twenty-four, not, however, without the extensive division of the capsular ligament and adjoining muscles. **These instances are**

certainly very encouraging, but they should, nevertheless, be received with great caution, especially when it becomes necessary to view them as examples for our imitation. It should not be forgotten, as stated elsewhere, that the greatest possible differences prevail in regard to this subject; that in one case a dislocation may become irreducible in several weeks, and in another not under several months, depending upon the individual circumstances of each.

Perhaps the best plan that can be adopted in these chronic cases is to be guided by the degree of motion that has been acquired by the luxated bone. When this is considerable, it may be assumed that it has succeeded in establishing for itself a new joint, which it might be dangerous to disturb on account of its important relations with the surrounding parts. Another consideration which should have its weight is the amount of inflammation by which they are followed; if this has been unusually violent, it may be inferred that there has been copious plastic effusion, filling up the original socket, and causing extensive adhesions among the muscles and vessels, matting them firmly together, and rendering interference hazardous.

When it is deemed advisable to attempt reduction, a certain amount of preliminary treatment should always be instituted, with a view of facilitating the breaking down of the abnormal adhesions between the head of the displaced bone and the surrounding parts, so as to lessen the danger both of failure and of injury to the axillary vessels and nerves, after the application of the extending and counter-extending forces. In general, a resort to the pulleys will be required, and, in some cases, the apparatus of Dr. Jarvis might possibly be advantageously used.

Notwithstanding the greatest care that can be exercised in these operations, the issue is occasionally most disastrous. The accidents that are most liable to occur are, severe contusion of the soft parts, fracture of the humerus, and laceration of the axillary artery. A number of instances have been related in which death was produced either by shock or by the severity of the resulting inflammation.

The skin and muscles must often, of necessity, be much bruised, and the latter sometimes even partially lacerated, in these operations. The occurrence may be brought about simply by the long-continued pressure of the heel in the axilla, or by the use of special apparatus, and is not unfrequently attended with extensive abrasions of the surface and more or less infiltration of blood in the connective tissue of the axilla and side of the chest.

The axillary artery has been ruptured in a considerable number of instances, and the result, in nearly all, has been promptly fatal. The disastrous cases recorded by Verduc, Petit, Loder, Delpech, Cooper, Pelletan, David, Flaubert, Bell, Gibson, and others are well known to surgeons, and should serve as warnings in regard to rude and protracted interference in accidents of this kind, sometimes even when they are not of long standing. That such an occurrence should happen is not at all singular when it is recollected how liable dislocations of the shoulder are to be followed by severe inflammation and copious deposit of lymph, firmly gluing the axillary artery to the surrounding parts, and thus necessarily endangering it in any forcible attempts that may afterwards be employed to restore the head of the humerus to its natural position. The necessary result of such an injury is, of course, an aneurism, generally of a diffused nature, and characterized by the ordinary phenomena, as the sudden formation of a tumor in the axilla, and the cessation of pulsation at the wrist.

The circumscribed form of aneurism is uncommon as an effect of this accident. Two typical cases of it have been recorded by Dupuytren and Nélaton, in each of which a considerable period elapsed before the tumor attained much bulk. In the former the swelling was mistaken for an abscess, which was opened by mistake, and followed by fatal hemorrhage. In the other case, that of an old woman who had a subglenoid luxation that was easily reduced, the subclavian artery was ligatured.

The axillary vein has sometimes been lacerated. Froriep has related an instance of this kind in a woman twenty-six years old. The axilla became suddenly enormously distended with blood, and death occurred in an hour and a half. The dislocation had existed only twenty days.

A number of instances of laceration of the axillary nerves have been reported as having occurred in attempts to reduce old dislocations of the shoulder. The accident is necessarily followed by more or less paralysis of the superior extremity. A more common effect is severe contusion of these cords, with pain and œdema of the limb, and temporary impairment of function.

Fracture of the humerus has occurred in the hands of some of the most distinguished surgeons. The portion most liable to give way is the surgical neck, and the accident always happens during the violent efforts that are made to force the head of the bone out of its abnormal position while the arm is pressed forcibly across the chest, the strain thus produced being concentrated at the superior extremity of the humerus. The event is generally indicated by a loud noise or snap.

It is not improbable that in a very old person the ribs might be fractured in efforts of this description by the pressure of the heel in the axilla or by the use of Jarvis's adjuster. I am not aware, however, that any cases of such a nature have been recorded.

The proper treatment of these several occurrences will readily suggest itself. When the axillary artery is ruptured, the most correct plan is at once to expose it by a free incision, and to ligate it at each extremity, as in aneurism of a similar nature in other parts of the body. When the tumor is circumscribed, and of slow formation, ligation of the subclavian artery, as practised in one case by Nélaton, would be proper. Large extravasations of blood in the armpit generally readily disappear under the influence of sorbefacient remedies, especially strong solutions of hydrochlorate of ammonia.

Congenital Dislocations.—Congenital dislocations of the shoulder-joint have been particularly studied by Mr. Robert W. Smith, who directed special attention to them in his excellent work on fractures published in 1847. Since then they have been examined with much care by Gaillard, Guérin, Nélaton, and others.

The malposition, which may be single or double, sometimes coexists with similar displacement in other articulations. Only two varieties have hitherto been recognized by dissection, termed, by Mr. Smith, the subcoracoid and the subacromial, the head of the humerus in the former being lodged beneath the coracoid process, and in the latter on the dorsal surface of the scapula, below the outer and posterior part of the acromion. The latter might, perhaps, more properly be called the infra-spinous form of the luxation.

The symptoms of both these dislocations are well marked. In the subcoracoid variety, the shoulder has a flattened appearance, especially at its upper and posterior aspect, the acromion is unnaturally sharp and prominent, there is a remarkable hollow in the supraspinous fossa, and the head of the humerus may readily be felt beneath the coracoid process, forming a distinct ball, which promptly obeys the movements of the elbow. The arm, which hangs along the side, is greatly withered, thus singularly contrasting with the forearm and hand, which generally retain their full development, being in fact quite as well conditioned as the opposite limb. The movements of the scapula are perfectly normal, while those of the arm are either annulled, or very much impeded, especially abduction; the forearm can be bent, but not actively extended. The movements, on the contrary, of the hand and fingers, are nearly, if not entirely, natural.

In the subacromial dislocation the head of the humerus may easily be felt on the dorsum of the scapula, a short distance below the root of the acromion, where it forms a distinct, unmistakable prominence. The deltoid muscle is flattened externally and in front; the acromion is uncommonly salient; the arm, shortened and withered, is rotated inwards towards the trunk; and the forearm and hand are slightly pronated, supination being executed with great difficulty.

Dr. Rodrigue, of Pennsylvania, has reported an instance of intra-uterine dislocation of the shoulder-joint complicated with fracture of both bones of the forearm, caused by a fall of the mother near the middle term of pregnancy. The head of the humerus lay in the axilla, and could not be restored to its normal position.

The treatment of these dislocations must be conducted according to the general principles laid down in a previous page. In a remarkable instance, Gaillard succeeded in effecting the reduction of a congenital luxation of the shoulder-joint in a girl sixteen years of age, who recovered with a most excellent use of the arm. For several weeks prior to the operation, the parts were daily subjected to passive motion and manipulation, so as to induce them to yield the more readily to the necessary extension and counter-extension. The inflammatory symptoms that followed the reduction were combated by the usual means.

Dislocation of the Tendon of the Biceps.—The tendon of this muscle is liable to be dislodged, by being violently wrenched from its bed in the humerus, and, perhaps,

partially torn, if not completely snapped asunder. In the latter case, the upper extremity of the tendon may float loosely about within the joint. The accident generally happens from falls or blows upon the shoulder, forcing the humerus away from the glenoid cavity of the scapula, generally upwards and inwards against the coracoid process, or forwards against the ribs. It may also occur from falls on the hand or elbow, especially if, at the moment, the limb is very much twisted upon its axis. The nature of the lesion is always obscure, and, therefore, very apt to be overlooked or to be mistaken for fracture, sprain, or dislocation of the shoulder. The most reliable symptoms are, inability to flex the arm from the loss of power in the biceps, and pain at the seat of the injury, either alone, or in conjunction with more or less prominence of the head of the humerus. Reduction should be attempted by thorough relaxation of the affected muscle by bending the forearm at a right angle with the elbow, and then pressing the tendon back into its proper place with the fingers. The after-treatment should be strictly antiphlogistic, otherwise there will be great danger of permanent ankylosis of the joint. If the tendon is completely severed, the limb will always be weak. In the adjoining drawing, fig. 45, from a preparation of Mr. Sodon, the tendon of the muscle lay with its sheath on the lesser tubercle of the humerus.

Fig. 45.



Dislocation of the Tendon of the Biceps Muscles.

3. INFERIOR EXTREMITY.

DISLOCATIONS OF THE FOOT.

Luxations of the *phalangeal* and *metatarso-phalangeal* joints are uncommon, and are mostly of so complicated a character as to require amputation. The reduction is always easy.

Of dislocation of the *great toe* at the metatarsal joint, a very infrequent accident, I have seen two cases, one recent and the other old. The following is a brief history of them.

A gentleman, forty-two years of age, struck the dorsal surface of the foot against a lump of coal, bending the great toe downwards and dislocating it at the metatarso-phalangeal articulation. The accident, which caused considerable pain, was so well marked as to be at once recognized. The toe, inclined somewhat outwards, lay a little higher than in the natural state, and was fully half an inch shorter than the sound one. The head of the first phalanx rested upon the dorsal surface of the anterior extremity of the metatarsal bone, where it formed an abrupt, well-defined prominence. The projection on the plantar surface, formed by the head of the metatarsal bone, was less conspicuous. The adductor muscles of the great toe formed a broad, tense cord at the inner side of the foot. I saw the man within an hour after the accident, before there was any swelling or discoloration of the parts; and having placed him under chloroform, I applied a clove-hitch knot to the toe, and readily drew it into place, the extension being made forwards and slightly downwards, to disengage the head of the phalanx from the anterior extremity of the metatarsal bone. The foot was steadied by an assistant grasping the ankle.

In the other case the foot was caught between two steamers, which twisted off the man's boot, severely wrenching the limb, and bruising the soft parts. The phalanx of the big toe was forced below the metatarsal bone, forming a large prominence in the sole of the foot, which has ever since, now a period of six years, been a source of much annoyance, being frequently so sore and tender as to interfere materially with progression.

The reduction of this luxation is occasionally attended with considerable difficulty, depending probably upon the manner in which the adductor muscle and the sesamoid bones are dragged by the displaced phalanx backwards over the extremity of the metatarsal bone. In the event of such a contingency an attempt might be made to

effect restoration by means of Dr. Crosby's plan of reducing dislocations of the thumb, raising the toe perpendicularly, and then applying strong pressure against its base, so as to push it from behind forwards, and from above downwards.

The *metatarsal* bones are rarely dislocated, owing to the firmness of their connections both with each other and with the lower row of tarsal bones. The accident is most commonly compound. A simple luxation, however, of one or more of these bones, is sometimes occasioned by a violent wrench of the foot, or by the passage of the wheel of a carriage, as happened to me in a case, many years ago, in which the fourth and fifth metatarsal bones were detached from their connections with the cuboid bone, and thrown upwards upon the tarsus. The reduction was effected with great facility, and, under the employment of leeches and other antiphlogistics, the man was able in the course of a fortnight to exercise on crutches, regaining eventually a good use of his limb.

The only case of a complete dislocation of all the metatarsal from the tarsal bones of which I have any knowledge, was communicated to me by Dr. Traill Green, of Easton, Pennsylvania, as having occurred under his observation and that of Dr. Edward Swift. The patient, a man, sixty-five years old, in falling down a flight of stairs, injured the left foot, which was found soon after the accident to be much swollen over the arch and very painful, with deformity at the inner and outer edge. The metatarsal bone of the great toe was separated from the internal cuneiform bone, and thrown over towards the outer margin of the foot, leaving the latter bone quite prominent at the inner side. A similar condition existed on the opposite side, the metatarsal bone of the little toe being thrown off completely from the cuboid bone, so as to present a well-marked projection at the outer border of the foot. In short, the twisted state of the foot, the great deformity, and the swelling of the arch, clearly indicated a lateral displacement of all the metatarsal bones.

The reduction was easily effected. The patient being placed in a half-reclining posture on a settee, with his right foot against the arm, to brace himself during the operation, an assistant applied his knee to the instep, and while he made extension by grasping the dislocated portion of the foot, previously surrounded by a wet roller, to prevent the lac from slipping, Dr. Green, who supported the leg upon his thigh, made strong lateral pressure, in a direction contrary to that of the displacement. The parts soon began to yield, and in a few minutes returned to their proper place with a distinct snap, all deformity at the same time disappearing.

Dislocation of the *tarsal* joints is uncommon, their limited motion and the strength of their ligaments forming so many obstacles to their disunion. The astragalus is almost the only bone which is liable to displacement, and this accident is also unusual.

Dislocation of the *cuneiform* bones is extremely infrequent. The internal one is most liable to suffer. The accident, of which a well-marked case was recently reported by Dr. Velder, of Elmira, New York, is usually caused by falls from a considerable height, in which the person alights upon the sole of the foot, the force separating the bone from its natural relations. A projection on the inside of the foot, and a slight elevation of the bone, from the action of the anterior tibial muscle, are the characteristic signs of the lesion. The reduction, which is difficult, is effected mainly by pressure. In two cases of this luxation, mentioned by Sir Astley Cooper, replacement was found to be impracticable. When this happens, the patient generally, in time, regains a tolerably good use of the limb.

Retention is maintained by adhesive strips, a compress, and bandage, aided by splints, to keep the foot in a quiet, easy position. When the inflammation has sufficiently subsided, a leather strap with a soft pad should be worn, to protect the parts until the reparative process is completed.

The *scaphoid* and *cuboid* bones are occasionally separated from their connections with the astragalus and calcaneum, in consequence of the falling of a heavy weight, or of a person jumping from a considerable height and alighting upon the sole of the foot. Under these circumstances the foot is shortened, and twisted upwards and inwards, forming a remarkable prominence upon the instep, which gives it a distorted appearance not unlike what occurs in *varus*. The accident, which is extremely infrequent, is easily remedied by fixing the leg and heel, and then drawing the toes outwards, in a direction contrary to that of the displacement. Suitable retentive means will be required to prevent a recurrence of the luxation.

The *calcaneum* may be dislocated from the cuboid bone laterally, in an outward

direction, by causes similar to those producing displacement of the other tarsal bones. The accident is easily detected and remedied by manipulation.

A remarkable instance of dislocation of the five anterior *tarsal* bones from the astragalus and calcaneum has been recorded by Sir Astley Cooper, as having occurred in a laboring man, from the fall of a very heavy stone. The foot was singularly distorted, exhibiting very much the appearance of clubfoot, the forepart being turned inwards upon the astragalus and calcaneum, so as to give the limb an arched shape. The reduction was easily effected by fixing the leg and heel, and pushing the luxated bones in a direction contrary to that of their displacement. A similar case has been recorded by Petit.

In the succeeding pages an account will be given of luxations of the *astragalus* from the mortise-like cavity of the tibia and fibula, and, without anticipating, in any way, what will then be said, it is important to bear in mind that the class of lesions which is now to be considered is very different from that of the ankle-joint, in which the bone in question plays so conspicuous a part. In the latter affections the astragalus is torn off simply from its connections with the tibia and fibula, but in those which are next to be described it not only loses its relations with these bones, but also with the calcaneal and scaphoid. The displacement may either be partial or complete, the astragalus in the former case still retaining some of its connections, whereas in the latter they are entirely lost, complete disruption having taken place, or, in other words, the bone is lifted bodily out of its original position into one altogether new. It is obvious that such an accident can only occur from the application of excessive violence, in which the foot is strongly extended upon the leg, and more or less rotated upon its axis. Hence it is always of a grave nature, and rarely unaccompanied by fracture of the inferior extremity of the tibia and fibula, which thus adds still further to its complications and dangers. Occasionally, indeed, the astragalus itself is severely shattered.

Dislocation of the astragalus may take place in two directions, backwards and forwards, the latter, which is by far the more frequent, admitting also of a certain degree of displacement laterally, or to either side, in consequence of a twist of the foot. In the posterior luxation the bone does not experience any rotation, and is, therefore, more in the course of the median line, suffering no material lateral deviation.

In the luxation *backwards*, of which only a few cases are known as having occurred, the astragalus is thrown behind the ankle, resting upon the superior surface of the calcaneum, where it forms a large, characteristic prominence. The tendo Achillis is pressed strongly backwards by the displaced bone, there is great tension of the skin of the heel, the muscles of the calf are very rigid, the tibia is slightly pushed forwards, and the instep appears a little shorter than natural. In general, also, there is a slight vacuity in front of the joint. The tibia and fibula are sometimes both fractured.

The reduction is attended with extreme difficulty, owing to the manner in which the surfaces of the astragalus and calcaneum are interlocked with each other, and I am not aware that the operation has ever succeeded, except in one case, which occurred to Mr. Liston, and in which the accident was attended with fracture of the tibia and fibula, which had probably the effect of rendering the parts more movable. In attempting to replace the bone, the leg and foot should be as strongly flexed as possible, so as to induce thorough relaxation of the gastrocnemial muscles, and then, while extension and counter-extension are made by means of the clove-hitch, the astragalus should be urged from behind forwards into its natural position. When the difficulty is very great, the parts absolutely refusing to yield to any efforts, however judiciously applied, recourse should be had to the subcutaneous section of the tendo Achillis, in the hope of promoting thereby restoration. The operation has succeeded in a number of cases.

When reduction fails, the patient will in time acquire a tolerably good use of his limb, the parts accommodating themselves gradually to their new relations. In one instance, where the attempts proved unsuccessful, the bone caused sloughing of the soft structures, and was obliged to be extracted.

The luxation *forwards* is generally incomplete, the anterior half of the bone, or a little more, resting upon the dorsal surface of the scaphoid bone, while the posterior half is imbedded in the hollow between the two articulating surfaces of the calcaneum. The displaced bone forms a distinct prominence over the instep, while a marked vacuity exists at the inner part of the foot, just below the corresponding

malleolus. The tibia and fibula either retain their natural position, lying upon the posterior surface of the astragalus, or, as more commonly happens, they are carried slightly forwards, thus increasing the length of the heel, and inclining the foot towards one side or the other, according to the peculiar relations which the bone may sustain towards the calcaneum, a trifling change of position being capable of determining the nature of the lateral displacement.

In the complete form of the accident, the bone is forced away entirely from its natural position, being tilted up in front of the joint so as to rest upon the scaphoid and cuneiform bones. The signs are characteristic, the large prominence at the instep, the constrained and twisted position of the foot, the shortening of the leg, and the descent of the malleoli towards the sole of the foot, together with the elevation and lengthening of the heel, being sufficient to reveal its nature at a glance.

Sometimes the position of the astragalus is almost completely reversed, and there are few cases which are unattended with fracture of the tibia and fibula, or even of the astragalus itself. Moreover, the dislocation is not unfrequently of a compound character, the soft parts being severely lacerated, and the wound extending into the ankle and tarsal joints; or, when such an effect has not been the direct result of the accident, the foot is soon reduced to that condition by the ulceration and sloughing caused by the pressure of the displaced bone upon the integument of the instep.

The great obstacle to reduction in this as in the backward dislocation is the mal-position of the astragalus, or the change in its axis, which not unfrequently baffles all the efforts of the surgeon at restoration, however well directed or perseveringly continued. Even when the displacement is only partial, the difficulty will generally be very great, although less than in the complete form, in which it is usually insurmountable. In the latter case, indeed, it is questionable whether, after what experience has taught upon the subject, it will hereafter be judicious to make any efforts at reposition, seeing how much all such trials, rough and protracted as they necessarily must be, must tend to aggravate the injury, and thus increase the risk of undue inflammation. When the displacement is partial, immediate recourse should be had to reductive means, consisting of traction and pressure, aided, if the case prove rebellious, by the subcutaneous section of the tendo Achillis and of any ligaments that may seem to act obstructingly. When replacement is impracticable, the tension of the parts should be relieved by subcutaneous incisions, as this will lessen the risk of sloughing and exposure of the bone; a circumstance inevitably productive of necrosis, and the necessity of partial excision. When such an accident can be prevented, it is consolatory to know that, as in the dislocation backwards, the bony surfaces become gradually adapted to each other, thereby ultimately permitting a tolerably good use of the limb.

When the bone is entirely displaced, lying immediately beneath the integument and muscles of the instep, the only safe procedure is immediate excision, the ends of the tibia and fibula being placed in the sulcus vacated by the removal of the astragalus, and the edges of the wound being carefully approximated by collodion, so as to insure their prompt reunion without risk of suppuration. Statistics strongly testify in favor of this plan of treatment. Thus, of fifty-two cases analyzed by Broca, forty-two terminated successfully. The operation, however, is not always free from difficulty, as is exemplified in an instance recorded by Dupuytren, in which the bone was extirpated only after a long and tedious dissection, owing to the pulley-like surface of the astragalus being turned downwards, while its posterior projecting part was hooked in under the tibia. Only about one person in four recovers with ability to move the ankle.

In *complicated* dislocations a similar procedure is proper; but here, if the injury be at all grave, the question of amputation will necessarily arise, and much judgment will generally be required to make a just decision. In all severe cases, involving extensive lesion both of the soft structures and of the bones, especially when occurring in weakly or sickly subjects, no experienced surgeon would for a moment hesitate as to the propriety of removing the limb; the only doubt that could possibly arise would be, whether the operation should be done through the leg or through the foot, according to Pirogoff's method.

The after-treatment of these cases requires no special mention. The great points are to give due support to the limb, and to moderate the resulting inflammation by

the bandage, leeches, and medicated lotions; and, eventually, by the institution of passive motion to prevent union between the calcaneum and the bones of the leg. If erysipelas should appear, as in severe cases it is very prone to do, early and free incisions will be necessary.

DISLOCATIONS OF THE ANKLE.

The dislocations of this joint are among the most infrequent of traumatic lesions, the mechanism of the articulation being eminently unfavorable to their occurrence. The length and width of the malleoli render lateral displacement of the astragalus almost impossible without concomitant fracture of one or both of these projections, while luxation in the antero-posterior direction is nearly as impracticable in consequence of the extraordinary strength and firmness of the ligaments connecting that bone to the tibia and fibula. The effect is that these injuries are almost always of a complicated character, their chief interest depending upon the violence done to the neighboring structures. Most of them, in fact, should be viewed in the light rather of fractures of the tibia and fibula, with displacement of the astragalus, than as dislocations, properly so called, of the ankle-joint. After a very careful examination of the records of surgery, I find that simple displacement of this bone, in any direction, is an occurrence of such extreme infrequency as hardly to deserve mention.

The ankle-joint may be dislocated in four different directions, forwards, backwards, inwards, and outwards. A few cases have been recorded in which the astragalus was forced upwards between the ends of the tibia and fibula; and Huguier has published the particulars of one where the foot was turned completely outwards, the toes forming a right angle with the leg, and the external malleolus representing the heel.

The nomenclature of these luxations has been the subject of a singular caprice, and, in consequence, the result of no little confusion. Instead of considering the astragalus as the dislocated bone, so as to place this joint in the same category, in this respect, as the other articulations, Sir Astley Cooper and others, adopting his example, have made it the fixed point, and the tibia and fibula the movable. This manner of viewing these lesions has occasioned a corresponding change of nomenclature, and as both are radically defective, serving only to cause embarrassment, they should be discarded.

1. Luxation *forwards*, the most infrequent of all, arises from falls on the heel, while the foot is forcibly bent upon the leg, the body being at the same time inclined forwards, so as to throw the strain upon the forepart of the joint. Under these circumstances the ligaments are extensively ruptured, and the astragalus, escaping from the mortise-like cavity of the tibia and fibula, rests immediately in front of the former bone, where it forms a large projection beneath the integument. The diagnostic signs are, the elongated state of the foot, the distance between the leg and toes being materially augmented, the remarkable shortening of the heel, and the effacement of the depressions behind the ankle from the close approximation of the tendo Achillis to the posterior surface of the limb.

The reduction is effected mainly by manipulation. As a preliminary step, the leg is flexed at a right angle with the thigh, to relax the gastrocnemial muscles, when an assistant, seizing the lower part of the leg, gradually pushes it forwards, while the surgeon, grasping the foot, and bending it considerably, forces it backwards, in the opposite direction. In rebellious cases the subcutaneous division of the tendo Achillis greatly facilitates restoration.

2. Dislocation of the ankle-joint *backwards* is caused by violence applied to the anterior extremity of the foot while it is immoderately extended, the knee being at the same time strongly flexed and projected forwards; or, the foot and leg being in this position, it may arise from a severe blow upon the lower and back part of the limb, the two forces driving the articulating surfaces in opposite directions. The displacement is ordinarily accompanied by fracture of the inferior extremity of the fibula.

The signs are the reverse of those which distinguish dislocation forwards. The dorsal surface of the foot is shortened, the toes pointing downwards; the heel is elongated and firmly fixed; the tendo Achillis, pushed far back beyond its natural position, stands out in bold relief; the pulley-like surface of the astragalus is readily

perceptible at the back part of the inner ankle; and the extremity of the tibia forms a hard prominence upon the instep, immediately beneath the integument.

The dislocation backwards is sometimes incomplete, one half of the articular surface of the tibia resting upon the scaphoid bone and the other half upon the astragalus. The foot, pointed downwards, cannot be put flat upon the ground, and the heel is raised and abnormally prominent, but less so than in complete luxation. A careful examination of the joint will at once reveal the true nature of the case.

The restoration is accomplished in the same manner as in the luxation forwards, the gastrocnemial muscles being thoroughly relaxed, and the bones pulled and pushed in opposite directions.

3. Luxation *inwards* is generally occasioned by falls or blows upon the foot, in which the astragalus is violently rotated upon its axis, and thrust against the inner malleolus, which is usually broken in consequence, being separated obliquely from the extremity of the tibia, as exhibited in fig. 46. It is also liable to be produced

Fig. 46.



Dislocation of the Tarsus Inwards.

by direct injury, as that caused by the passage of the wheel of a carriage. Sometimes the luxation is associated with fracture of the astragalus, or of this bone and the fibula, thus greatly aggravating the case.

The articular surface of the astragalus, pointing immediately below the internal malleolus, can easily be perceived in its new position; the foot is turned inwards, its outer border resting on the floor, while the inner is proportionately raised; and there is a remarkable prominence at the outer part of the joint, formed by the extremity of the fibula.

In reducing this dislocation, the leg is bent at a right angle with the thigh, and steadied by an assistant, while traction is made upon the foot, and the astragalus pushed back into its natural position.

Fig. 47.



Dislocation of the Tarsus Outwards.

Apposition of the articular surfaces is maintained by means of two side splints, or, what I prefer, with a tin case, well fitted to the size and shape of the limb, to afford the foot proper support until repair is effected.

4. Dislocation *outwards*, fig. 47, is the most frequent of all the displacements to which this articulation is exposed, a sudden twist of the leg, while the foot is firmly fixed, being the most common exciting cause, although it is often produced by direct violence. The articular, pulley-like surface of the astragalus is forced below the outer malleolus, and there is always fracture of the inferior portion of the fibula; without this, indeed, the occurrence would seem to be impracticable. This form of luxation has been described by most authors as displacement inwards.

In this variety of the accident, both malleoli are sometimes broken off, the superior surface of the astragalus slipping away from the articulating surface of the tibia, and lodging in the gutter between this bone and the fibula. The foot, in this case, is nearly flat, as the patient stands up, with a slight upward inclination of its inner margin, and the lower extremity of the tibia forms a remarkable prominence, rendered the more conspicuous on account of the displacement of the internal malleolus, which, when broken, is always drawn over towards the fibula. Great deformity also exists at the outer border of the ankle, caused by the projection of the inferior fragment of the fibula.

The signs of this accident are unequivocal. The inner malleolus forms a remarkable projection under the skin; the foot is twisted and easily rotated upon its axis, its inner border resting on the ground; a depression exists on the outer surface of the leg, above the joint, corresponding with the line of fracture of the fibula, and the astragalus can be distinctly perceived below the outer malleolus.

The reduction is effected by flexing the leg strongly, so as to relax the gastrocnemial muscles, and then drawing the articulating surfaces towards each other in a direction contrary to that of their displacement. The whole procedure is one of great simplicity. Maintenance is preserved by means of adhesive strips, so arranged as to keep the ends of the broken fibula in a straight line, and the articulating surfaces of the displaced bones in close apposition, due support being afterwards given to the foot by means of a tin case or side splints.

5. In the dislocation *upwards*, of which only a few cases have been recorded, the astragalus is forced upwards between the two bones of the leg, the fibula being fractured some distance above the joint, and widely separated from the tibia. The astragalus preserves its natural direction, but is so firmly impacted as to render its restoration difficult. The two malleolar projections are extremely prominent, and descend nearly as low down as the sole of the foot, which is usually inclined a little to one side. Occasionally, as in a case referred to by Mr. Drutt, fig. 48, the astragalus is thrown up between the tibia and fibula without any fracture of these bones.

The *after-treatment* in the luxations now described requires the most assiduous care and attention in order to prevent ankylosis. Anodyne and astringent lotions, and, in the more severe forms, free leeching, will be necessary to keep the inflammation within due limits. Proper support, in an easy posture, must be given to the leg and foot until all danger of displacement is over. Passive motion and sorbefacient remedies will complete the cure. In most cases, however, the joint will long remain weak, and, in not a few, loss of motion, partial or complete, will be inevitable.

The ankle is not unfrequently the subject of *compound dislocations*, the wound in the soft parts penetrating the cavity of the joint, and affecting, perhaps, the principal vessels and nerves of the limb, at the same time that there may be violent contusion of the integument, and extensive comminution of the bones of the leg. In such a case, which is well displayed in fig. 49, from a preparation in my collection, the surgeon could not hesitate as to the course to be pursued. Amputation alone can save life, and should be postponed no longer than is absolutely necessary for the occurrence of the requisite reaction. The lesion is profound, and any attempt to preserve the parts would be worse than foolish. When the injury is less violent, and the constitution sound, conservative surgery will often effect wonders, and is always worthy of a fair trial. When the ends of the bone protrude, excision will generally be the only safe course. Whatever conservative measure be adopted, more or less ankylosis will always be inevitable, although the patient may ultimately regain a tolerably good use of the limb.

Fig. 48.



Dislocation of the Astragalus Upwards between the Tibia and Fibula.

Fig. 49.



Compound Dislocation of the Ankle-joint.

DISLOCATIONS OF THE TIBIO-FIBULAR JOINTS.

Dislocation of the tibio-fibular joints is an extremely uncommon occurrence; for, independently of their peculiar mode of articulation, and the great firmness and strength of the connecting media, the resistance offered by the interosseous ligament,

and the protection which the fibula receives from its relations with the tibia, are so many causes which interfere with the disruption of their surfaces. It is only, indeed, the most violent injury that can give rise to the accident. There is a form of dislocation of the upper joint which occasionally occurs as a result of excessive relaxation of the fibulo-tibial ligaments, chiefly in weakly, delicate females, allowing the head of the fibula too much latitude of motion; but this is an occurrence very different from a genuine luxation, which is always occasioned by external force acting directly upon the component elements of the joint. Of the traumatic variety of the lesion only a few examples are on record. Boyer has published the particulars of a case in which both joints were displaced simultaneously, the foot being at the same time dislocated outwards. Such an accident necessarily implies extensive laceration of the interosseous ligament, and can only happen by a fall upon the foot, or a blow upon the inferior extremity of the fibula, driving the bone upwards and outwards with the whole force of its leverage. Whatever may be the nature of the displacement, reduction is always easily accomplished by flexing the leg at a right angle with the thigh, and pushing the bone back in a direction contrary to that of its luxation. Maintenance, which is usually very difficult, must be effected by long-continued rest of the limb, and the use of a broad, elastic strap with a closely-fitting pad, acting directly upon the head of the bone.

In the *subluxation*, as it may be termed, of the upper tibio-fibular joint, the most suitable remedies are chalybeate tonics, with gentle exercise in the open air, the cold douche, electricity, tincture of iodine, a series of little blisters, and the use of a proper supporter. If the case be rebellious, a delicate tenotomy knife may be introduced subcutaneously, and carried about the joint in different directions, in order to scratch the articular surfaces, so as to provoke an effusion of plastic matter.

DISLOCATIONS OF THE PATELLA.

It is obvious, from the situation of the patella and the manner in which this bone is imbedded in the tendon of the extensor muscles of the thigh, that it is susceptible of being dislocated only outwards and inwards, or laterally. Displacement downwards is altogether impracticable, while that upwards cannot happen without rupture of the ligament by which this bone is connected to the tibia. Each luxation may be complete or incomplete. A remarkable form of the accident, in which the patella is dislocated edgewise, vertically, or upon its long axis, is occasionally met with. Whatever the character of the displacement may be, the occurrence is extremely uncommon. It is most frequent in thin, feeble persons, in whom it is usually produced by very trivial causes, as, for example, a sudden twist of the limb in dancing, walking, leaping, or stepping into bed. When there is a faulty conformation of the knee-joint, attended with a relaxed state of the ligaments, it may take place spontaneously, from the action of the extensor muscles conjoined with slight rotation of the leg, the thigh being fixed in the straight position. Sometimes the displacement is occasioned by direct violence, forcing the bone towards the opposite side of the articulation, or twisting it upon its long axis.

The amount of injury sustained in these luxations by the ligaments of the knee is variable. When the displacement is partial, as it is in most cases, the probability is that the laceration is very slight, whereas in the more complete forms it must necessarily be proportionately extensive. In some instances the ligament of the patella is nearly torn across, and the lateral ligament is either very much stretched or ruptured.

Of the two lateral dislocations, that *outwards*, fig. 50, is the more common, the patella lying at the external part of the joint, its outer edge being directed backwards, and the inner forwards. The signs are characteristic. There is a remarkable depression in front of the knee, with a corresponding prominence on the outside; the inner

Fig. 50.

Fig. 51.



Dislocation of the Patella Outwards.

Dislocation of the Patella Inwards.

condyle can be distinctly felt under the skin, and the leg is in a painfully extended position, without the possibility of being flexed.

In the dislocation *inwards*, fig. 51, the situation of the patella is reversed, its inner border being turned backwards and the outer forwards. The leg is extended and cannot be bent; the outer condyle looks as if it were depressed, and a characteristic prominence exists at the internal aspect of the knee.

Restoration is effected by placing the patient upon his back, and flexing the thigh upon the pelvis, the lower part of the leg resting upon the surgeon's shoulder, as he sits upon the edge of the bed. The object of this procedure is to relax the knee as completely as possible, when, pressure being applied to the bone with the thumb and fingers, the patella will be drawn into its natural position by the action of the extensor muscles.

Although these dislocations are generally reduced with great facility by the method here advised, and very frequently even by the patient himself, cases occur in which the operation is extremely difficult, the most skilful surgeon being foiled for a long time, notwithstanding the best directed efforts. It is said that Sabatier completely failed in an instance of this kind; and Dorsey, on one occasion, nearly experienced a similar fate. Being called to a young lady who had luxated her patella in stepping into bed, he did not succeed in accomplishing his object until after many fruitless attempts, although he saw the patient within five minutes after the accident. When the obstacle is unusually great, it may generally be surmounted by forcibly flexing the leg, and then rapidly extending it; a procedure which has the effect of disengaging the bone from its impacted position.

The dislocation in which the patella is displaced edgewise, *vertically*, or upon its long axis, is a very singular accident, the possibility of which was long denied by nearly all surgeons. It is, indeed, difficult to conceive how a bone, which is so firmly imbedded as this is in tendinous matter, can lend itself to such a freak, which has the effect of turning it completely on its side, so that its outer edge lies immediately under the integument in front of the knee, while the inner rests in the subcondyloid fossa of the femur, being firmly and almost immovably wedged in its new position, the anterior face looking inwards, and the posterior outwards. Sometimes the position of the patella is almost completely reversed, the surfaces changing situations, the anterior looking backwards, and the posterior in the opposite direction. The occurrence, however, is very uncommon, as I am not able to find altogether more than thirteen recorded cases.

The accident is generally produced by violent muscular action conjoined with a sudden and forcible twist of the knee; occasionally, however, it is caused by a fall or blow upon the bone, the leg being semiflexed and strongly rotated upon its axis. A case has been related in which it occurred in wrestling; and at least two instances are known where it resulted from the forcible collision of the knees in a sham fight upon horseback. In a case reported by Professor Rochester, of Buffalo, the dislocation was caused by a fall, in which the patient, a youth of sixteen, struck the joint against a curbstone.

The signs are characteristic. The leg is perfectly straight, but may occasionally be slightly flexed, although not without excessive pain; the patella forms, by its outer edge, a hard, prominent ridge in front of the knee; a deep depression exists upon each condyle; and the extensor muscles are in a state of extreme tension.

The reduction is generally extremely difficult, owing, apparently, to the trouble which is experienced in disengaging the bone from the subcondyloid fossa, where it is almost as firmly impacted as if it were screwed fast. On several occasions, indeed, the most violent efforts, conjoined with the division of the ligament of the patella, were hardly sufficient to accomplish the object. In a case mentioned by Dr. Gazzam, of Pittsburg, the only effect of the operation was to render the bone a little more movable, but the attempts afterwards to reduce it were quite as unavailing as before. In another instance, the surgeon, Dr. Wolf, divided the ligament below, and the extensor tendon above, the bone, and yet he found it impossible to effect restoration. Violent disease of the joint ensued, and the patient ultimately perished from profuse discharge and hectic irritation. Fortunately, such measures are not likely to be again repeated, since experience has fully shown not only their utter inefficacy, but great danger.

The proper method of reduction consists in flexing the thigh strongly upon the pelvis, and in bending the leg forcibly, to the fullest extent, upon the thigh, the limb

being again immediately brought into a straight line, at the same time that an effort is made to push the bone strongly over towards the inner part of the joint. By repeating this manoeuvre several times in rapid succession, the patella suddenly leaves the subcondyloid notch, and jumps back, with a distinct snap, into its natural situation. Extension, even when carried to excess, is of no avail in effecting reduction; on the contrary, in every case, except one, recently under the care of Dr. Coombs, in which it has been tried, it has signally failed, by causing, apparently, still further impaction of the bone.

After the reduction of these different dislocations, the patient must be subjected for some time to rest and the usual antiphlogistic measures; and when he is able to move about, the joint must be supported for many months with a laced gum-elastic cap.

Displacement of the patella *upwards* can only occur when there is a rupture of the ligament of that bone, in consequence of the inordinate action of the extensor muscles, or violence applied to the anterior surface of the knee. The injury is easily recognized by the flattening of the joint, by the projection upon the inferior part of the thigh, and by the inability of the patient to extend the limb. The treatment is precisely the same as in fracture of the patella.

A few instances of *congenital* luxation of the patella are upon record; some of them of an equivocal character, others well authenticated. The occurrence is very uncommon.

DISLOCATIONS OF THE KNEE.

Dislocation of the knee is of very infrequent occurrence, owing, mainly, to the numerous and powerful ligaments by which the articulating surfaces are united together. In this respect, there is no other joint in the whole body so well provided. If it were not for this arrangement, luxation could hardly fail to be very common, as the knee not only admits of extensive motion, but has unusually shallow surfaces, with no very strong support from the neighboring muscles, such, for instance, as exists in the hip, shoulder, and elbow.

The tibia may be thrown from the condyles of the femur in four different directions, forwards, backwards, inwards, and outwards, or to either side. The latter two are the most common, and are always incomplete, owing to the great extent of the articular surfaces, and the difficulty of rupturing all the ligaments in the lateral direction of the joint. In regard to the dislocations forwards and backwards, it

was generally supposed, until lately, that they were always complete, but the accurate researches of Malgaigne have proved that they are most frequently partial. Besides these displacements, the knee is subject to a species of subluxation, dependent upon a change of location of the semilunar cartilages. This, indeed, is more common than all the other forms of the lesion together, and is, therefore, of sufficient importance to demand separate notice.

1. Dislocation *forwards*, fig. 52, is occasioned by falls upon the foot while the knee is in a bent position, or by force acting upon the anterior and inferior part of the thigh, driving the femur backwards behind the head of the tibia; in either case, the occurrence will be promoted if, at the moment of the injury, the leg is slightly rotated on its axis, so as to increase the strain upon the joint.

The head of the tibia is pushed upwards and forwards, lying in front of the condyles, and generally presenting a somewhat twisted arrangement; the patella is drawn up beyond its natural level, into a sort of hollow, just above the tibia, and may easily be lifted up with the thumb and fingers; the tendon of the extensor muscles is much relaxed; and there is shortening of the leg from an inch and a half to two inches. The condyles of the femur are situated in the ham, where they form a large tumor, which gives the part an unusually prominent appearance, and which occasionally exerts such a degree of compression upon the vessels as to interrupt the circulation in the dorsal artery of the foot.

Fig. 52.



Dislocation of the Tibia Forwards.

The complete form of dislocation of the tibia, whether forwards or backwards, must necessarily be attended with most extensive rupture of the ligaments of the joint, and is, therefore, always to be regarded as a very serious accident. When the condyles are impelled backwards with unusual violence, there will be great danger of laceration of the popliteal vessels, especially of the artery, either in the form of direct rupture, or of a partial destruction of its inner and middle tunics; occasioning, in the one case, copious subcutaneous hemorrhage, the pressure of which may finally cause gangrene of the limb; and, in the other, the gradual dilatation of the artery into an aneurismal tumor, the ultimate effects of which may not be less disastrous. In every instance there is rupture of the popliteal muscle. When the injury to the joint and the parts around is very grave, the danger to limb and life may be such as to require amputation; but, ordinarily, the patient rapidly recovers from the immediate effects of the lesion, and eventually obtains a useful limb, although it may remain weak for a long time.

The reduction is readily effected by counter-extending the thigh and pulling the leg somewhat backwards, the surgeon's arm resting in the ham, and pressure being made upon the head of the tibia.

The following case, the only one that I have ever seen of dislocation of the head of the tibia forwards, affords a good illustration at once of the symptoms of the accident, and of the proper method of reduction.

A very large, stout, heavy woman, forty-eight years of age, received a severe fall from the sudden slip of the right foot, which, bending outwards, caused the whole weight of the body to be thrown upon the corresponding knee. I saw her four hours after the occurrence of the accident, when several fruitless attempts had already been made at reduction. The knee, which was very painful and a good deal swollen, appeared to be unusually wide from side to side; a circumstance partly due to the tumefaction of the soft parts. The leg was one inch and a half shorter than the opposite one, and in a straight line with the thigh. The patella had sunk behind the head of the tibia, into a kind of hollow, which imparted to the front of the joint a flattened aspect. Upon grasping the bone, however, with the thumb and fingers, it was easily drawn forwards, leaving a remarkable vacuity behind, in consequence of its distance from the inferior extremity of the femur. The condyles of the thigh-bone lay in the popliteal space, posterior to the head of the tibia, where they formed a large prominence, more distinct on the inside than on the outside, and situated, as it were, in the upper and back part of the leg, the muscles of which were unusually tense. The head of the tibia lay in front of the condyles, where its outline could easily be traced with the eye and finger. Above this bone, as already stated, was the patella with its ligament and the tendon of the extensor muscles, forming a broad, thick cord in front of the thigh-bone, from which it was removed more than two inches. The leg was easily drawn away from its fellow, but could not be carried inwards, showing that there was extensive rupture of the internal lateral ligament. There was no contusion of the soft parts, nor any discoloration of the integument.

Chloroform having been administered, a stout lac was applied to the upper part of the thigh, and confided to an assistant, to make the requisite counter-extension, while extension was made by another assistant grasping the foot, the limb being in the extended position. Placing now my left forearm behind the knee, and requesting the aids to pull gently and steadily, I suddenly, with my right hand, bent the leg backwards, and thus in a few seconds effected the reduction, the bone returning with a distinct snap. The limb being laid in an easy position, cold cloths were applied to the knee, and a grain of morphia administered to allay pain and prevent spasm.

No untoward symptoms appeared after the reduction. The patient kept her bed for nearly a fortnight, and made free use, after the first twenty-four hours, of medicated lotions, to moderate and subdue inflammation. Purgatives and light diet were also enjoined. In due time passive motion was instituted; the limb was frequently bandaged; and in less than a month from the time of the accident, the woman was able to walk about the house with the aid of crutches. The joint, however, remained weak for a long while, and even now, several years after the occurrence of the injury, the slightest fatigue is attended with temporary lameness.

2. Luxation of the tibia *backwards*, fig. 53, is so rare an accident that the possibility of its occurrence was called in question by many of the older surgeons. Modern experience, however, has not only shown the error of this opinion, but has pointed

Fig. 53.

Dislocation of the Tibia
Backwards.

out with great accuracy the mechanism, signs, and method of reduction of the displacement. The causes are similar to those of luxation forwards.

The head of the tibia lies in the ham, where it compresses the popliteal vessels and nerves, pushes back the popliteal and other muscles, and forms a distinct prominence, easily perceptible by sight and touch. In front of the joint is the large projection representing the condyles of the femur, and immediately below it the patella, with a strongly marked depression on each side, its ligament being drawn tightly under the articular surface of the thigh-bone, and the tendon of the extensor muscles firmly stretched. The leg, which has the appearance of being slightly rotated, is always considerably shortened, although less than in the luxation forwards. In regard to its position no definite rule can be laid down, as it varies much in different cases, being at one time flexed, at another extended.

The reduction is effected upon the same principles as in the dislocation forwards, the thigh and leg being pulled in opposite directions, and pressure made upon the head of the tibia, while the patella is fixed by the hand in front.

3. The *lateral* dislocations of the tibia are always incomplete. They occur with nearly equal frequency, generally from falls, or from the passage of the wheel of a carriage, in which the femur is violently twisted while the leg itself is firmly fixed. Another cause is force applied to the lower and lateral part of the leg at a moment when the knee rests upon a hard, resisting object, and the trunk is inclined side-

ways, thus throwing the whole strain upon the edge of the joint. Much injury of the soft parts almost always attends these displacements, and the leg generally presents a remarkably twisted appearance.

Fig. 54.

Dislocation of the Tibia
Inwards.

Fig. 55.

Dislocation of the Tibia
Outwards.

In the luxation *inwards*, fig. 54, the head of the tibia is thrown off the corresponding condyle of the femur, and forms a large tumor at the inner side of the knee. In the displacement *outwards*, fig. 55, the signs are reversed, the tibia projecting at the external aspect of the joint, and the condyle at the inner. The leg, in both cases, is slightly flexed and rotated on its axis, the extensor muscles are relaxed, and a marked depression exists in the natural situation of the patella, which is pushed to one side or the other, according to the character of the displacement. The diagnostic signs are the twisted state of the limb, and the great increase of the width of the joint.

Owing to the extensive laceration of the ligaments of the joint, the lateral dislocations are reduced with great facility. All, in fact, that is necessary, is, while the thigh is fixed by an assistant, to pull the leg by grasping it just above the ankle, and to push the head of the tibia in a direction contrary to that of its displacement.

The after-treatment of all these luxations must be conducted upon strictly antiphlogistic principles. The patient should be confined to his bed for at least a month, and blood should be freely taken by leeches, and even by the lancet, if he is robust, or if the inflammation runs at all high. The great danger is ankylosis, which it will require the utmost care and diligence to prevent. The joint must be supported in an easy position, and passive motion must not be instituted too soon, lest it interfere with the reunion of the ruptured ligaments. When the patient is able to walk, the knee must be protected with a laced cap, and its tone improved by the cold douche, stimulating embrocations, and dry friction.

Complicated dislocations of the knee are not of infrequent occurrence, and are

always to be dreaded on account of the constitutional sympathies which they are apt to awake. When the joint is laid freely open, and the soft parts are otherwise seriously injured, there can hardly be any doubt as to the propriety of immediate amputation, for such cases nearly always terminate unfavorably, the patient dying either of tetanus, erysipelas, pyemia, traumatic fever, or excessive suppuration; or, if he chance to recover, he will owe his life to good luck rather than to the skillful management of his attendant. It is generally difficult to make the patient comprehend the importance of what will always appear to him so harsh a measure, especially if he is a young man of temperate habits, and in excellent health at the time of the injury; he will resist the operation in spite of the arguments and entreaties of his surgeon, and will only consent when it is too late to be of any benefit to him. I am satisfied that there is no class of lesions more dangerous both to life and limb than compound dislocations of the knee, especially when at all severe; and I, therefore, do not hesitate to recommend the prompt adoption of decisive measures. When the soft parts are not too much affected, excision may advantageously be substituted for amputation, although, in general, the latter is unquestionably by far the safer procedure.

Dislocations of the knee are sometimes complicated with laceration of the popliteal vessels, and, in such an event, the only resource is amputation of the thigh, performed without delay, immediately above the seat of the injury. Mr. George Lowe recently reported two cases in which this expedient was necessary.

Examples of *congenital* luxation of this joint have been reported by different authors, as Cruveilhier, Robert, Guérin, Kleeberg, and Bard. The displacement, which is generally incomplete, and associated with other malformations, may occur in any direction, but that forward is by far the most common.

In 1863, Dr. Karsner sent to my clinic at the College a female child, two years of age, on account of a congenital dislocation of each knee, accompanied by absence of the patella. The tibia lay in front of the femur, the situation of its head being indicated by a distinct prominence, and by a peculiar crescentic fold in the skin. The condyles of the thigh-bone, on the contrary, formed a very large tumor on the back part of the leg, and seemed to have been considerably rounded off. The leg was shortened about two inches and a half. The child, which was puny and unhealthy, could readily extend the limb, as well as move it laterally, but was unable to flex it at the joint, nor could this be done beyond a few inches by my own efforts. The dislocation was reduced by extension and counter-extension, but immediately recurred upon their cessation.

DISLOCATIONS OF THE SEMILUNAR CARTILAGES.

The semilunar cartilages are subject to a species of displacement known under the name of *subluxation*, an affection which was first described by Mr. Hey, of Leeds, and which is most commonly met with in feeble, delicate persons, the subjects of chronic disease of the knee. A sudden and forcible twist of the joint occasioned by striking the toes against a stone, or an accidental slip in walking while the foot is turned inwards and the thigh outwards, is the usual cause of the mishap. The lesion essentially consists in the partial removal of the semilunar cartilages from their natural position, thus allowing them to become wedged in between the tibia and femur, simply as an effect of the relaxed condition of their ligamentous connections. Occasionally, however, the wrench is so violent as to detach some of these connections from the bone.

Well-marked *symptoms* always attend this form of luxation. The patient is suddenly rendered conscious of some accident, which causes him to feel faint and sick, and immediately compels him to sit down. The pain is very excruciating, and he is unable to stand, or to extend the limb, which is generally semiflexed. If the joint be examined within a few minutes after the occurrence of the injury, its size and shape will be found to be perfectly natural, and an inexperienced surgeon might conclude that the case was merely a slight sprain. In a short time, however, considerable swelling sets in, and the articulation before long imparts a distinct sense of fluctuation from the deposit of synovial fluid, caused by inflammation of its lining membrane. The excessive pain and shock are due to the pressure which the tibia and femur exert upon the displaced cartilages, in consequence of the changes in their mutual relations, and, also, to the forcible distension of some of the ligamentous structures of the joint. The dislocation, having once taken place, is extremely

liable to recur from the most trivial causes; and under such circumstances I have repeatedly noticed that, although the patient was always obliged to keep his leg in a slightly bent position, yet he was able, when he sat on a high seat, to move it nearly as well as the sound one.

The *reduction* should be performed under chloroform, otherwise it will be very painful. The most eligible position is the recumbent, with the thigh strongly flexed upon the pelvis. The surgeon, placing his arm in the popliteal hollow, and grasping the limb just above the ankle, bends the knee suddenly and forcibly, and then rapidly extends it, at the same time imparting a movement of rotation to the leg. By this triple manœuvre the pressure of the condyles is taken off from the semilunar cartilages, and the parts are enabled to return to their natural situation. Sometimes the ingenuity of the patient enables him to effect reduction when that of the surgeon fails. Sir Astley Cooper mentions the case of a gentleman who was in the habit of relieving himself by bending the thigh inwards and pulling the foot outwards, as he was sitting on the floor. In some instances, again, the parts return of their own accord after the usual means have failed, either while the patient is seated, or lying asleep in bed.

It is always proper after such an occurrence to keep the joint for a few days perfectly at rest, until it has, in some degree, recovered its original tone. When the patient begins to exercise, he should wear a laced knee-cap, and guard against any sudden twist of the limb, a recurrence of the dislocation being, as already stated, extremely liable to happen after all injuries of this kind. Sorbefacient liniments and the cold douche will be of service in promoting the removal of effused fluids, and imparting vigor to the relaxed structures.

DISLOCATIONS OF THE HIP-JOINT.

Dislocations of the ilio-femoral joint are far less frequent than those of the shoulder, a circumstance which evidently depends more upon the peculiarity of structure of these articulations than upon any difference in their motions, which are sufficiently free and varied in both, although certainly less so in the former than in the latter. The hip-joint affords the best type of the ball and socket joint with which we are acquainted. The acetabulum is of immense depth, and, therefore, furnishes ready accommodation to the large and well-formed hemisphere which constitutes the head of the femur. The glenoid cavity of the scapula, on the other hand, is very shallow, and yields very inadequate support to the head of the humerus, in the varied and extensive movements of the shoulder. Besides, there is a great difference in the ligaments which bind the bones to each other in these articulations. The capsular ligament of the shoulder is comparatively weak, while that of the hip is by far the most powerful in the body, at the same time that it is most closely and firmly fitted around the parts which it is designed to retain and to protect. In addition to this, the latter has a ligament peculiar to itself, the interarticular, which serves to connect the head of the bone directly to the margin of the acetabulum, an arrangement which is altogether wanting in the shoulder, the long head of the biceps forming a very imperfect substitute. Finally, the hip-joint is under the cover and protection of large and powerful muscles, which are much more capable of resisting the effects of dislocating agents than those of the shoulder, which, in fact, often rather promote the occurrence of the accident, if they do not actually produce it by their own ill-directed efforts.

Dislocations of the hip-joint are much less frequent in women than in men, simply because of the differences in their occupations. If women were as much exposed to all kinds of external violence, especially to falls and blows, as the other sex, they would, doubtless, suffer quite as often, not only from these accidents, but also from luxations of the other articulations. Displacements of the shoulder occur at least from six to eight times as frequently in the male as in the female, and in the ilio-femoral joint the disproportion is still more remarkable.

Displacement of this joint is, next to that of the shoulder, more frequent than in any other joint of the body. Of the cases collected by Malgaigne, 491 in all, 321 occurred in the shoulder and 34 in the hip, the clavicle coming next in order.

Age exerts an extraordinary influence upon the production of these accidents. It is very uncommon to meet with a luxation of the hip-joint in children, because a degree of force capable of inducing it in the adult would be more likely to lead to

separation of the epiphyses of the bone, owing to its imperfect development, and consequent inability to resist external injury. In the old the lesion is also unusual, for at that period of life the osseous tissue is so brittle as to be liable to be broken by the slightest causes. Hence, fracture of the neck and upper extremity of the femur is much more frequent in both sexes after the age of fifty-five than displacement of the head of that bone from the acetabulum. Dislocation often occurs from the twentieth to the twenty-fifth year, but is most common from the thirtieth to the forty-fifth. The youngest case of displacement of the hip-joint on record happened at eighteen months; the oldest, at eighty-six years.

The head of the femur is susceptible of being dislocated in four principal directions; upwards, upon the dorsal surface of the ilium; backwards, into the sciatic notch; downwards, into the thyroid foramen; and forwards, upon the pubic bone. Of these displacements, the first is by far the most common; next in order of frequency is that into the sciatic notch, and the rarest of all is the last. Sir Astley Cooper, whose experience in dislocations of the hip-joint was very great, estimated that out of every twenty cases twelve would be on the dorsal surface of the ilium, five in the sciatic notch, two in the thyroid foramen, and one on the pubic bone. Of 104 cases of these accidents, collected by Professor Hamilton, 55 were iliac, 28 sciatic, 13 thyroid, and 8 pubic. The observation of surgeons generally accords with the results of these statistics. To the extreme rarity of the last two forms of luxation every practitioner can bear testimony. The reason of the great frequency of iliac dislocations is to be found, I presume, rather in the position in which the thigh is usually placed at the moment of the accident than in any differences in the structures of the hip-joint at particular portions of its extent, certain attitudes of the limb always favoring the occurrence of certain displacements.

Besides these varieties of luxations, there are several others, which will be briefly noticed under another head, as rare, unusual, or anomalous dislocations of the hip-joint. Their occurrence is exceedingly infrequent.

It will greatly simplify the study of the four principal forms of this accident if they be described as the iliac, sciatic, thyroid, and pubic, terms which every one understands, and which cannot fail to convey a clear general idea of the locality of each displacement to which they refer.

All these luxations are complete, the head of the femur being forced entirely out of its socket. Great violence is necessary for their production, and they always take place so much the more easily in proportion as the force is diffused over a large surface. I am not acquainted with a solitary instance in which they were the direct and immediate result of muscular contraction, as occasionally happens in dislocations of the shoulder-joint. Such an event could only occur when there is previous disease of the articulation, destroying its ligamentous connections. In what is called a spontaneous luxation, of which a number of examples are upon record, the displacement is always partial, the head of the femur never completely forsaking the cotyloid cavity. The violence in these accidents may act either directly upon the hip, or indirectly through the knee or foot, and the nature of the displacement will depend upon the direction in which it is applied. Thus, luxation into the thyroid foramen can only be produced when the limb is powerfully abducted at the moment of the accident, and the occurrence will be promoted if the strain is increased by the person having a heavy weight upon his shoulder.

A simultaneous dislocation of both hip-joints is occasionally met with, as in an instance recorded by Professor William Gibson; but such an occurrence is exceedingly uncommon. The accident may be symmetrical, or the head of one bone may lie in one situation and that of the other in another, as in a case recorded by Mr. Couper, of London, in which one displacement was iliac and the other thyroid. A similar example occurred to Dr. Boisnot, of this city, in a man, forty-two years of age, who was crushed by the fall of a heavy sack of wool, in which one thigh-bone was luxated upon the ilium and the other upon the pubic bone.

In every dislocation of the hip there must necessarily be extensive injury of the soft parts. The capsular and interarticular ligaments are torn, and the same fate is nearly always experienced by the rotator muscles of the femur. The two large gluteal muscles, however, and the psoas and iliac, which are attached to the small trochanter, usually escape, or are, at most, only put upon the stretch. When the violence has been uncommonly severe, a considerable effusion of blood may be

expected in and around the joint, and there will be likely also to be more or less contusion of the integument and muscles, especially if the injury has been direct.

1. In the *iliac dislocation*, the head of the femur is thrown upwards and backwards upon the dorsal surface of the ilium, fig. 56, resting in the fossa of that bone, either under or upon the small gluteal muscle. In some cases, though rarely, it is thrust a good deal forwards instead of backwards.

The accident occasionally occurs very early in life. The youngest case on record is one of eighteen months, treated by Dr. Fanning, of Catskill. Kirby and Buchanan

Fig. 56.



Fig. 57.



Dislocation on the Back of the Ilium.

met with it at three years; Image at three and a half; Litten at four; Travers at five; J. C. Warren at six; Sir Astley Cooper at seven. I have seen it at six and at fourteen years, in male patients sent to me, respectively, by Dr. Whiteside, of Haddington, and by Dr. Saulsbury, of Delaware.

The *symptoms* of the accident, fig. 57, are sufficiently obvious, exhibiting rarely any material variation. The hip is considerably deformed, being more salient than natural, the upper part of the thigh is unusually full, and the gluteo-femoral crease is on a plane higher than common. The great trochanter is carried upwards and inwards, in closer proximity with the anterior superior spinous process of the ilium, and is more conspicuous than in any other accident except coxalgia. The head of the bone may readily be felt in its new situation, particularly in thin, lean subjects, and on rotating the thigh it is found to roll about under the finger. The limb is from one and a half to two and a half inches shorter than in the normal state; the foot is strongly inclined inwards, the big toe pointing towards the opposite tarsus; the knee, as the patient stands, is a little above and somewhat in advance of the sound one, any attempt to turn it out proving impracticable, and causing severe pain; the thigh is slightly bent upon the pelvis, and may with a little effort be carried across the sound one; the leg is flexed upon the thigh; the heel is raised off the floor; and the limb, firmly fixed in its constrained position, cannot be restored to its proper length without reducing the dislocation, nor can it be moved except a little inwards. When the patient lies down, the foot rests on the bed, but the knee is considerably raised, and all attempts to extend it are unavailing.

The luxation is generally occasioned by falls upon the knee or foot while the thigh is strongly adducted and thrown forwards beyond the line of the body. In this way the head of the femur, being powerfully rotated inwards, is thrust forcibly upwards and backwards, tearing the capsular ligament in that direction, escaping from the acetabulum, and lodging in the lower part of the iliac fossa, under or upon the small gluteal muscle. The accident may also be produced by violence applied directly either to the hip or to the upper extremity of the femur, as by the fall of a

heavy body, when the limbs are widely separated, and the trunk is inclined strongly forwards. The two obturator, geminal, square, and pyriform muscles are greatly stretched, and sometimes even partially ruptured, while the psoas and iliac are relaxed, as are also the adductor, pectineal, and gluteal. The round ligament is, of course, torn. The powerful tension into which the external obturator muscle, a fleshy mass of large size and great strength, is thrown by the accident, is the immediate cause of the immobility of the limb, of the inversion of the foot and knee, and of the excessive pain which follows any attempt at rotation and abduction.

The *diagnosis* is deduced from the great prominence of the trochanter and its proximity to the anterior superior spinous process of the ilium; the inverted and shortened state of the limb; the fixed position of the head of the bone in its new situation; and the impossibility of abducting and rotating the knee.

The only accident with which this luxation is most likely to be confounded is fracture of the neck of the femur, fig. 58, within the capsular ligament. In general, however, the diagnosis is established with great facility. All, in fact, that is necessary is to remember that, in fracture, the trochanter is drawn backwards and is less salient than usual; that the foot is everted instead of being inverted, as in luxation; that the limb may readily be restored to its proper length by extension, but immediately resumes its former position when the extension is discontinued; and, finally, that, when the ends of the fragments are brought in contact with each other, crepitation may promptly be elicited by rotating the thigh. Moreover, the limb may be moved, although not without great suffering, in every direction, and not merely inwards and slightly upwards, as in dislocation. In impacted fracture, a very rare occurrence, the head of the bone may always be felt in its natural position.

Doubt in regard to the diagnosis occasionally arises from injury of the superior extremity of the femur, attended with fracture of the great trochanter, from the detached fragment being drawn upwards and backwards by the action of the muscles, into the fossa usually occupied by the head of the bone in luxation. The signs of distinction are, the mobility of the broken piece, the absence of inversion of the limb, and our ability to carry the thigh about in different directions, although not without severe pain.

Severe contusion of the great trochanter, unaccompanied by fracture of the bone, may occasion uncertainty in regard to the diagnosis. The accident is liable to be followed by great pain and swelling in the upper part of the thigh and groin, by inability of motion, and by complete eversion of the limb, which, at the same time, feels numb and heavy, and is often swollen throughout its entire length. The absence of shortening of the limb, and the facility with which the head of the bone moves in its socket, are the signs which serve to distinguish the lesion from dislocation.

The symptoms of iliac dislocation are sometimes painfully simulated by a fracture of the acetabulum, allowing the head of the femur to escape into the pelvis. Or, a portion of the margin of this cavity may be broken off, and the bone ascend into the iliac fossa. The distinction is based upon the existence of crepitation and the greater amount of injury sustained by the soft parts. When the cotyloid border is detached, the fact will be denoted by the incessant tendency to recurrence of the dislocation after reduction.

The degree of shortening attending the iliac variety of displacement is best ascertained by extending a piece of tape, or a graduated measure, from the anterior superior spinous process of the ilium to the centre of the tuberosity of the internal condyle of the femur on each side. Or, instead of this, the tape may be carried along the middle line of the body, from the centre of the fourchette of the sternum to the sole of the foot, placed at a right angle with the leg. The difference in the result will indicate the extent of the defect. There is considerable variation in regard to the amount of shortening in different cases. On an average, it may be stated to range from two inches to two inches and a half; but occasionally it is as

Fig. 58.



Intracapsular Fracture of the Thigh-bone.

much as three inches and a half, and, on the other hand, as little as an inch and a half.

The limb, in this variety of luxation, instead of being inverted, is occasionally everted; sometimes in a remarkable degree, and without any ascertainable cause. In cases of this kind the diagnosis must hinge mainly upon the absence of crepitation and the great rigidity of the affected limb from the impaction of the head of the thigh-bone. Shortening is usually a prominent symptom.

It is surprising that writers should invariably insist upon stating that there is less prominence of the great trochanter in this variety of luxation than natural, whereas a little reflection will serve to show that such an opinion is altogether untenable. To prove the truth of this remark, it is only necessary to examine the position which the femur assumes in consequence of the dislocation. The whole limb being strongly rotated inwards, the trochanter, as it lies in its new situation just above the rim of the acetabulum, or partly above and partly below, is necessarily tilted up and brought forwards, so as to augment, in a very striking degree, its saliency beneath the integument and muscles of the gluteal region. An excellent idea of the changes produced in the projection of the trochanter may be formed by alternately inverting and everting the foot strongly in the ordinary standing attitude, so as to make, on the one hand, the big toe of the rotated limb point against the opposite tarsus, and, on the other, the heel against the hollow between the tendo Achillis and the inner malleolus. In the former position, the bony eminence will be remarkably prominent, jutting out as a rounded mass, whereas, in the latter, it will hardly be perceptible, or, at most, comparatively small. In displacement of the head of the bone upwards and backwards, the projection is abnormally distinct, and is, therefore, a sign of great diagnostic value.

2. The *sciatic dislocation* commonly results from falls or blows applied to the foot or knee while the body is strongly inclined forwards upon the thigh, or the thigh upwards upon the pelvis. In either case the head of the bone, breaking through the posterior and lower part of the capsular ligament, slips backwards from its socket, and takes up its abode in the sciatic notch, fig. 59, resting upon the pyriform muscle,

Fig. 59.



Fig. 60.



Dislocation into the Sciatic Notch.

between the sciatic ligaments and the convex surface of the iliac bone. The capsular ligament is severed, and the psoas, iliac, and obturator muscles are put upon the stretch, and occasionally otherwise injured. In a case observed by Mr. Syme the head of the bone rested upon and compressed the sciatic nerve.

This dislocation in its *symptoms* bears so close a resemblance to the iliac that some writers are disposed to regard them merely as modifications of the same lesion, the one being an exaggerated form of the other. I have myself, however, always looked upon them as separate and distinct varieties, and shall, therefore, so consider them here. The adjoining sketch, fig. 60, conveys an excellent idea of the appearances presented by the injured limb, and a comparison between it and the preceding will serve to show that they differ from those of the iliac luxation only in being less marked. The limb is shortened from half an inch to an inch, and so firmly impacted in its new position that it is impossible to bend or rotate it; the great toe rests against the ball of the sound one; the knee is turned in and advanced over its fellow, but not so much as in the dislocation upwards; the trochanter, which is uncommonly prominent, is lower down than natural, and, consequently, further off from the anterior superior spinous process of the ilium; and the head of the bone is so deeply buried in the sciatic hollow as to render it very difficult to detect it by the finger, except in thin, emaciated persons. Both the thigh and leg are slightly flexed.

The characteristic signs of the dislocation are, the situation of the head of the bone behind and below the acetabulum, a short distance above the tuberosity of the ischium; the comparatively slight shortening of the limb; the firm impaction of the thigh in its new locality; and the unusual distance between the trochanter and the spine of the ilium.

In a case of sciatic dislocation recently under my charge, in a rather thin man, twenty-eight years of age, I found the limb upon a most accurate examination to be nearly one inch shorter than the sound one, and strongly flexed at the knee. When an attempt was made to bring the thigh and leg in a straight line, the man complained of severe pain, and immediately raised his loins, so that it was quite easy to pass the fist and arm underneath. When the body was extended, the knee became immediately bent, as at the time of the accident. The limb lay close by the side of its fellow, and could not be carried either backwards or outwards, but was easily flexed on the pelvis. When the man stood up, he threw his body very much forward, and the limb hung close by the side of the other, the knee being far in advance of the sound one and crossed somewhat over it; the foot was almost parallel with the other, but the heel was raised from the floor nearly two inches. Both in standing and lying, the trochanter was at least one inch further off from the anterior superior spinous process of the ilium than the opposite one, besides being unusually prominent; and the head of the femur could be distinctly felt on the dorsal surface of the ilium, at the upper part of the sciatic notch, rolling under the finger when the limb was rotated upon its axis.

In a case of unreduced sciatic dislocation of the left side, of eight years' standing, in a man twenty-five years old, I found, upon dissection, great inversion of the knee and foot, shortening to the extent of nearly one inch and a half, and great wasting of the entire limb. The external gluteal muscle was nearly normal, but the middle and internal were excessively atrophied, shortened, and fused together, their fibres being very pale, sparse, and partially transformed into fatty and fibrous tissue. The pyriform, also much reduced in size, was stretched over the head of the femur, and inseparably blended with the inner and middle gluteal. The geminal muscles and the tendon of the internal obturator were elongated, and twisted around the neck of the bone. The quadratus was lengthened, but not otherwise perceptibly changed. The great trochanter was three inches and a half from the anterior superior spinous process of the ilium, and four inches and a half from the crest of that bone, its top being on a line perpendicular with it. The head of the femur lay across the upper part of the sciatic notch, two inches from the tuberosity of the ischium, and a few lines from the posterior inferior spinous process of the ilium, its distance from the crest of that bone being two inches and three-quarters. It was nearly completely divested of cartilage, very rough, and studded with numerous little bony eminences. Surrounding it was a false capsule, varying in thickness from the fourth of a line to a line and a half, and composed principally of the remnants of the pyriform and the two small gluteal muscles; it was translucent at several places, rough on its inner surface, with here and there a serous, glistening point, and presented a large quantity of reddish, filamentous tissue, immediately below the head of the bone, to which and to its neck it was firmly adherent. The ilium and sciatic ligaments which accommodated the bone were sound, and it was evident, from the manner in which the parts had been impacted, that but little

motion existed after the accident. The acetabulum was nearly filled by a fibro-cartilaginous substance, its edges having been rounded off by absorption. No trace could be discovered of the capsular and round ligaments.

3. In the *thyroid dislocation*, fig. 61, the head of the femur is thrown downwards and forwards into the thyroid foramen, resting upon the external obturator muscle, by which that opening is covered in, the great trochanter being turned backwards towards the acetabulum. It is caused by falls upon the foot or knee while the thigh is widely separated from its fellow, and inclined sharply backwards. It may also be occasioned by a heavy body, such, for example, as a sack of corn; striking the hip while the limb is in a state of abduction, and the trunk bent forwards. The gluteal muscles are drawn downwards, considerably flattened, and put upon the stretch; the pyriform is elongated and tense; the interarticular ligament and the lower portion of the capsular ligament are torn; and the extensor muscles of the thigh form a hard, firm mass, reaching from the pubic bone to within a short distance of the knee.

The thyroid dislocation occasionally occurs at a very early age, as in a case in the practice of Professor Bigelow, of Boston, in a child two years old.

Fig. 61.



Fig. 62.



Dislocation into the Thyroid Foramen.

The *symptoms*, as seen in fig. 62, are remarkably prominent and distinctive. The hip is deprived of its convexity, and in place of the projection formed by the trochanter there is a decided flattening, and sometimes even a positive depression; the trochanter, moreover, is removed considerably further from the anterior superior spinous process than in the natural state. The limb is increased in length from an inch and a half to two inches, and, owing to the tension of the gluteal muscles, stands off in an awkward and constrained manner from the sound one, the knees being in consequence widely separated from each other. The trunk is bent forwards by the action of the psoas and iliac muscles, which are greatly stretched; and a large tumor is perceptible in the region of the thyroid notch, caused by the presence of the head of the femur, which, however, can only be felt distinctly in thin subjects, and in the absence of swelling. The knee is flexed, and much in advance of the sound one, and the foot, usually a little everted, is widely separated from its fellow. The movements of adduction, extension, and rotation are impracticable, but those of abduction and flexion may be executed by the surgeon, although not without excessive suffering.

When the patient stands erect and is viewed in profile, the body and limbs are found to form an obtuse angle with each other, owing to the contraction of the glu-

teal muscles, on the one hand, and to that of the iliac and psoas, on the other, the latter presenting at the same time a tense ridge at the side of the thigh, perceptible both by sight and touch; the toes rest on the floor, while the heel is usually somewhat elevated; the hip, by its flattened condition, contrasts strikingly with its fellow; the femoro-gluteal crease is lower than natural; and the knee is greatly in advance of the opposite one. If the body be extended so as to bring it on a line with the thighs, the effort will not only fail, but cause severe pain.

The diagnosis is based upon the widely separated state of the knees, the elongation of the limb; which does not exist in any of the other luxations of the hip, the forward inclination of the body, the flattened state of the buttock, the excessive tension of the iliac and psoas muscles readily felt by the finger, and the impossibility of adducting, extending, and rotating the leg. Another valuable sign is afforded by the great trochanter, which will be found to be further off from the anterior superior spinous process of the ilium than its fellow on the opposite side.

4. The *pubic dislocation* is so uncommon that it might almost be classed among the rare forms of the accident. As the name implies, the head of the femur lies upon the horizontal branch of the pubic bone, or, rather, upon this bone and the iliac, fig. 63, above Poupart's ligament, and between the anterior inferior spinous process of the ilium and the femoral vessels, under cover of the iliac, psoas, and straight muscles. The displacement is caused by falls while the limb is pushed backwards and outwards, and there is a heavy load upon the shoulder, as when a man carries a bag of wheat, and his feet suddenly give way under him. Another mode in which it may be produced is by the sudden bending of the body backwards while the foot is implanted in a ditch or hollow and the femur is kept straight by the action of its extensor muscles. Under these circumstances the head of the bone ruptures the upper and inner portion of the capsular ligament, and slips out of its socket into

Fig. 63.



Fig. 64.



Dislocation on the Pubes.

the groin. Mr. Ure, of London, has reported a case in which the dislocation was caused by inordinate muscular contraction in the act of "striking out," as it is termed, in swimming. The man, who felt a peculiar catch in the right groin, which he attributed to cramp, was able to walk, although not without considerable difficulty, after the accident, and the reduction was readily effected by manipulation.

In this luxation, fig. 64, the limb is from half an inch to an inch shorter than the other; the foot and knee are everted, and separated from their fellows, although in a

less degree than in the thyroid displacement; the buttock is flattened; the great trochanter lies nearer the middle line than naturally; the femoro-gluteal fold is above its ordinary level; and a distinct prominence, hard, rounded, and easily impressed by moving the leg, exists in the groin, just above Poupart's ligament, representing the head of the femur. Adduction and rotation inwards are impracticable. In a case of pubic dislocation seen by Physick, in 1805, the head of the bone lay below Poupart's ligament, and the limb was a little longer than the sound one. Larrey has recorded an instance in which the femur projected nearly at a right angle with the body.

The flattening of the buttock, the slight shortening of the limb, the eversion of the toes, the impossibility of rotating the thigh inwards, and the existence of the head of the bone in the groin, are marks which sufficiently characterize the accident to prevent mistake.

General Diagnosis.—Error of diagnosis in dislocations of the hip-joint can only be avoided by the most careful and thorough examination of the patient, not only once, but, if necessary, repeatedly. It will be well always, in the first instance, to make the patient stand up, in order to observe what posture he assumes, and what control, if any, he may have over the injured limb. After this has been done, he should be fully anæsthetized, and examined as he lies upon his back, his side, and his abdomen, the limb being moved, if possible, in different directions, and measured with a graduated tape to ascertain whether there is any change in its length.

Upon comparing the four varieties of luxations above described with each other, it will be found that, with the exception of the first two, there are sufficiently broad marks of dissimilarity to render the diagnosis, with a little care, very easy. The thyroid is the only one in which there is any lengthening of the limb; in all the others it is shortened, least in the pubic, and most in the iliac. In the iliac and sciatic the hip is abnormally prominent; in the other two it is flattened; in the former the knee and foot are inverted, in the latter they are everted, decidedly in the pubic variety, and generally very slightly in the thyroid. In all the head of the bone may generally, with a little care and patience, be perceived by the touch in its abnormal position, especially in thin persons, and before the occurrence of much swelling, rolling about when the leg is rotated upon its axis. The great points to be attended to, when there is any doubt respecting the diagnosis, are, the state of the limb as to the change in its length, axis, and movements; the position of the great trochanter, especially its distance from the anterior superior spinous process of the ilium; and the location of the head of the bone and our ability or inability to feel it in its new situation. All that is necessary is to give proper heed to these considerations, and any uncertainty that may exist as to the true character of the injury will soon vanish. The investigation will, of course, always be materially facilitated by the use of an anæsthetic.

When all the ordinary means, such as the most thorough and patient examination with the touch, sight, and mensuration, fail, the mystery may often be solved with the exploring instrument, inserted at various points of the hip, and moved about in different directions in search of osseous prominences and depressions. A long, slender needle, sinking in to a great depth in the natural situation of the acetabulum, would infallibly declare the absence of the head of the thigh-bone, as the existence of an unusual osseous tumor outside of that cavity would certainly indicate the location of that bone in its new position. As there are no important vessels or nerves in and about the hip, such a procedure would be entirely free from the danger of hemorrhage and even pain. My opinion, however, is that, although perfectly safe and easy, it will rarely be necessary in any case, the nature of the lesion being generally too well marked to elude detection.

Reduction by Manipulation.—The experience of the last twenty years satisfactorily shows that all the different dislocations of the hip-joint may, at least in their recent state, be reduced by simple manipulation, not unfrequently even without the aid of anæsthetics. For our knowledge of this fact we are indebted mainly to Dr. W. W. Reid, of Rochester, through whose agency the operation was first brought into general notice. In a paper, published in 1857, he clearly proved, by a series of well-executed experiments, dissections, and clinical observations, that replacement may nearly always be safely, certainly, and expeditiously effected without any assistants, pulleys, or, in short, any extraneous aid whatever. He erred, however, in supposing that the chief obstacle to restoration was the contraction of the muscles around

the hip-joint, more especially those that are put upon the stretch by the malposition of the luxated bone. It remained for Professor Gunn, of Chicago, and Professor Moore, of Rochester, to show that the resistance is due, in great measure, if not exclusively, to the manner in which the untorn portion of the capsular ligament girds the head and neck of the femur; for, whenever this structure was thoroughly divided upon the dead subject, the reduction was generally very easily effected. In the iliac and sciatic forms of the accident an additional obstacle is occasionally presented by the pressure exerted by the iliac portion of the fascia lata upon the great trochanter when the limb is in this unnatural position.

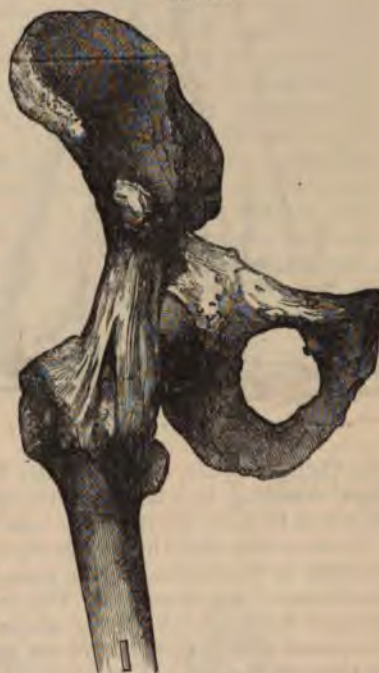
Professor Henry J. Bigelow, of Boston, in an exhaustive monograph on the "Mechanism of Dislocation and Fracture of the Hip," published in 1869, ascribes the difficulty of reduction exclusively to the resistance offered by the ilio-femoral, or, as he terms it, the Y ligament, which, as he affirms, always remains intact in the regular luxations of this articulation, whereas in the irregular or anomalous, as they are denominated, it is always torn. A similar opinion was enunciated by Von Pitha, of Vienna, in 1865.

The ilio-femoral ligament, hitherto regarded by most anatomists simply as an accessory ligament to the capsular, or, indeed, as an essential portion of it, is attached, on the one hand, to the anterior inferior spinous process of the ilium, and, on the other, to the anterior intertrochanteric ridge by two fan-like slips, its general outline thus closely resembling the letter Y. Its width, at its origin, is only about half an inch, whereas below it is more than four times that extent. It is remarkably tough and strong, nearly three lines thick at its greatest point of development, and capable, as Professor Bigelow has shown, of resisting a weight of two hundred and fifty to seven hundred and fifty pounds. The annexed sketch, fig. 65, affords a graphic illustration of the form, situation, and attachments of the ligament, as delineated in the work above mentioned.

The method of reducing luxations of the hip-joint by simple manipulation was occasionally pursued by some of the older surgeons, and it is even dimly shadowed forth in the writings of Hippocrates; it was distinctly recognized by Wiseman, in the seventeenth century, and successfully practised in the eighteenth by Turner, Anderson, and others; Physick employed it in a case of pubic dislocation, in 1811; and its feasibility was taught, for many years, by Professor Nathan Smith, in his annual courses of lectures delivered at New Haven.

The process of reduction consists of certain stages and evolutions, in which the shaft of the femur is employed as a lever, and the pelvis as a fulcrum, the object being, in the first instance, to dislodge the bone from its new situation, and then to induce the muscles to assist in drawing it into place, compelling it thus, as it were, to retrace its steps along the route travelled in the dislocation. In conducting the operation, the best plan is to make the patient lie upon the floor, as this affords a much firmer base of resistance than a lounge, bed, or table, and likewise gives the surgeon an opportunity of placing himself in any position that may be deemed advisable. Complete anæsthesia should be induced; and, if the patient be unusually stout and plethoric, blood may advantageously be taken from the arm, as a preliminary measure, although this will seldom be required. In the female, exposure of the person is avoided by means of a sheet. Everything being ready, the surgeon, grasping the knee with one hand, and the leg immediately above the ankle with the other, flexes the thigh upon the pelvis and the leg upon the thigh, such a step being absolutely necessary to relax the capsular and ilio-femoral liga-

Fig. 65.



Ilio-femoral Ligament.

ments. The thigh, in the iliac displacement, is carried across its fellow at the union of its middle and upper third, and then simply rotated inwards. In the sciatic variety, the reduction is effected in the same manner, with this difference, that the limb is lifted high up across the opposite groin. In the thyroid luxation, the thigh, raised to a right angle with the pelvis, is, at first, abducted, and then strongly rotated inwards. In the pubic form of the accident, the thigh, after being elevated in the usual manner, is, in the first instance, abducted and drawn downwards, and then rotated inwards.

Professor Bigelow, after having thoroughly relaxed the ilio-femoral ligament, the chief point of resistance, as he believes, in these luxations, by flexion of the thigh and leg, employs either rotation or vertical traction, the direction of the movement being regulated by the form of the displacement. If the opening in the capsular ligament is too small to admit of easy reduction, it may readily be enlarged, as a preliminary measure, by circumducting the limb in a direction opposite to that in which it is designed to carry the head of the bone. For making vertical extension, which affords the most complete relaxation of the ilio-femoral ligament, Professor Bigelow employs the tripod, represented in fig. 66, the pelvis being

Fig. 66.



Bigelow's Tripod for Vertical Extension.

secured to the floor by a padded band. Rotation may be effected by means of the transverse rod above the knee, while the head of the femur is carried from the dorsum of the ilium or the pubes in the direction of the tuberosity of the ischium by vertically raising the longitudinal rod attached to the calf of the leg. Such a contrivance is, of course, only adapted to hospital practice.

In old dislocations, additional obstacles to reduction exist, depending upon the rigid and contracted condition of the muscles of the hip and the adhesions formed by the plasma effused in consequence of the injury sustained by the affected structures. The period at which these impediments attain their full force must, of course, vary in different cases and under different circumstances. In an iliac luxation of one month's duration, under my charge, in 1855, in a very stout, muscular young man, I promptly succeeded in effecting replacement by simple manipulation, after complete failure with the pulleys employed for nearly an hour and a half, the patient being all the while thoroughly relaxed by chloroform. In 1863, at

the College Clinic, I was equally fortunate, in a similar dislocation of twenty-seven days' standing, in a lad fourteen years of age. Successful examples of much longer duration have occurred in the hands of other surgeons.

In the pubic and thyroid dislocations, reduction has occasionally been effected by the heel in the perineum, the patient and surgeon lying in opposite directions, as in luxations of the shoulder. The pelvis being thus firmly fixed by the foot, extension is made by grasping the leg above the ankle, the limb being gradually carried over the sound one as the head of the bone approaches the cotyloid cavity. Or, instead of this, the leg may be flexed at a right angle with the knee, and a long, stout noose secured around the lower part of the thigh, and thrown over the operator's neck and shoulder, which will thus afford him much greater control over the limb. This method, however, which recommends itself by its simplicity, is chiefly applicable to very thin, feeble subjects, offering but little muscular and ligamentous resistance.

Dr. Brainard, of Chicago, in four cases of thyroid dislocation, promptly succeeded in effecting reduction by placing a piece of well-padded wood, four inches and a half in diameter, as a fulcrum, in the perineum, between the thighs, which were then used as levers, the limbs being extended during the operation, and the affected one carried

slightly across the sound one. Occasionally a bedpost has been used for a similar purpose; but, in employing such an expedient, care must be taken not to raise the leg, otherwise the head of the femur may be thrown into the sciatic notch.

Reduction with the Pulleys.—When manipulation fails, as it occasionally will, especially in very stout, robust persons, and in chronic cases, recourse must be had to the pulleys, for then even severe measures would be preferable to leaving the luxation unreduced, and letting the patient remain a cripple for life. The general principles which should guide the practitioner in the use of these instruments have already been pointed out. I shall, therefore, limit myself here to a brief description of the operation as applicable to the several varieties of dislocations of the hip, premising that the employment of the pulleys is, at best, an expedient of doubtful efficacy, often productive of much greater harm than benefit.

The patient should be laid upon his back on the floor, or on a firm table, lounge, or bed, between two strong objects, from ten to twelve feet apart, in each of which a large hook is fixed. A stout, soft piece of muslin, neatly folded, and at least four yards in length, is placed in the perineum, and being carried over the groin and buttock, its ends are tied together, and fastened to the hook behind the patient's head. Another band is carried around the upper part of the pelvis, and given to an assistant, to prevent the injured hip from being drawn down during the operation. Finally, a large wet towel is rolled around the lower part of the thigh, and over this is buckled a leather band with two lateral straps, each provided with a ring. Or, instead of the band, a stout fillet is employed, being fastened by means of a wet roller, or the French knot, the ends being so disposed as to come down on each side of the knee, a little below which they are to be tied. The knee being now bent nearly at a right angle, and inclined a little across its fellow, the pulleys, secured to the extending band and the staple, are put in motion by gently drawing the cord. As soon as the apparatus is thoroughly put upon the stretch, and the patient begins to evince symptoms of suffering, as he will be sure to do if he has not taken chloroform, the efforts are to be relaxed, to allow the muscles time to become fatigued. After having waited a few minutes, the cord is again tightened, so as to increase the tension a little further, when the efforts are to be again intermitted. Taking care to proceed in this slow, gentle, and gradual manner, until the head of the femur has reached the edge of the acetabulum, the surgeon intrusts the management of the cord to an assistant, while he himself, grasping the upper part of the leg, rotates the limb in a direction contrary to that of its displacement, and thus promotes the return of the bone to its socket, the reduction being generally indicated by a distinct snap. When the head of the bone hitches against the brim of the acetabulum, its disengagement may be materially facilitated by means of a fillet placed around the groin, and thrown over the operator's neck and shoulder, so as to enable him to lift the bone up to a level with the cotyloid cavity, into which it will then be drawn by the contraction of the muscles. The length of time during which the action of the pulleys is maintained must depend upon circumstances, the restoration, in some cases, being effected in a few minutes, in others not under several hours.

Fig. 67.

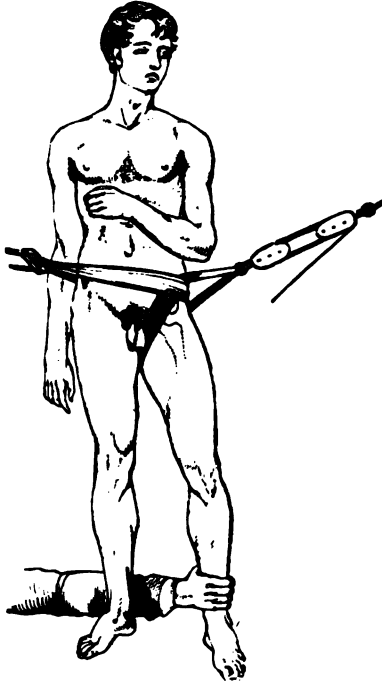


Reduction of the Iliac Dislocation with the Pulleys.

The annexed cut, fig. 67, illustrates the position of the patient during the operation, the arrangement of the pulleys and the extending bands, and the position of the limb.

In the iliac and sciatic dislocations the rule is to let the patient lie on his back, and, after the extension and counter-extension have been kept up for some time, to

Fig. 68.



Reduction of the Thyroid Dislocation.

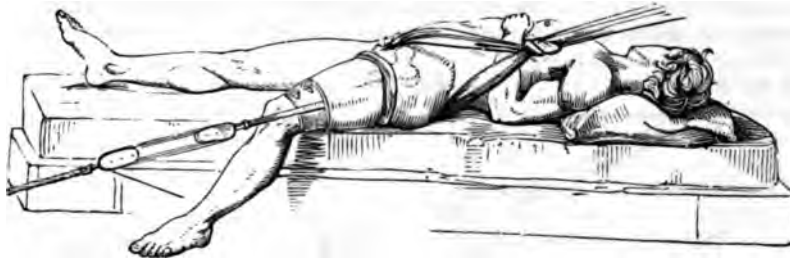
carry the affected limb across the opposite one, as this enables the head of the bone the more easily to disengage itself from the brim of the pelvis. In the thyroid and pubic varieties the extension is directed downwards and backwards, the foot of the affected limb being carried behind the sound one, and the patient lying upon the uninjured side. The manner of conducting the proceeding is represented in figs. 68 and 69.

In the attempts at reduction, the head of the bone, instead of returning to its socket in the act of being lifted out of its abnormal position, occasionally drops into some other, from which it may, perhaps, be more difficult to dislodge it than it was in the first instance. This accident is most liable to occur in the iliac luxation, which, as the head of the femur is moved about to disengage it from the iliac fossa, is readily converted into the sciatic. In a case reported by Dr. F. D. Lente, the head of the bone was thrown from the sciatic notch upwards under the anterior superior spinous process of the ilium. Occasionally the pubic displacement is changed into the thyroid; and an instance happened at the Pennsylvania Hospital, in the service of Dr. Neill, in which, during the reduction, the bone was thrown out of the thyroid foramen into the sciatic notch, from which it was afterwards returned with great difficulty by means of the pulleys. These accidents are generally unavoidable; but a knowledge of the possibility

of their occurrence should put the surgeon upon his guard, that he may not be deceived under an idea that he has effected reduction when he has only succeeded in producing another displacement.

When the head of the bone has resumed its original position, as may always be known by the disappearance of the symptoms, and by a comparison of the limb with its fellow, a return of the accident is to be prevented by keeping the thighs

Fig. 69.



Reduction of the Pubic Dislocation.

close together by means of a handkerchief or strip of bandage tied just above the knees. Recumbency will be necessary for at least three weeks; and during the first eight or ten days the hip should be kept constantly covered with cloths wrung out of a strong solution of acetate of lead and laudanum. If the inflammation run high, leeches, active purgation, antimonial and saline preparations, and even general bleeding, may be demanded. After the morbid action has measurably subsided, sorbefacient lotions, and passive motion of the joint will be required, to promote the removal of plastic matter, and to prevent ankylosis.

It is seldom that any of the luxations of the hip recur after the bone has been

properly replaced, for such are the depth of the acetabulum and the nice adaptation of the head of the femur as to render an event of this kind extremely difficult after recovery from the immediate effects of the injury. A remarkable instance, however, occasionally occurs, in which the same displacement happens frequently, in more or less rapid succession, in the same person. Thus, Mr. John F. South gives the case of a woman, who, in thirteen years, dislocated her femur upwards and backwards upon the ilium not less than twenty-one times; latterly from so trivial a cause as stooping, or turning in bed. The accident originally happened when she was twenty-four years old, from slipping on a piece of orange peel. In this case the frequent recurrence of the displacement was doubtless due to extensive rupture of the ligaments of the joint; but now and then it is found to depend upon fracture of the border of the cotyloid cavity. However induced, the accident is always to be deplored, because it is generally irremediable.

ANOMALOUS DISLOCATIONS OF THE HIP-JOINT.

The hip, like the shoulder, is subject to certain forms of displacement, to which, from the infrequency of their occurrence, the term rare, irregular, or anomalous may be applied. They are perhaps, for the most part, merely exaggerated states of the more ordinary varieties of the accident produced, as Professor Bigelow has shown, by the rupture of the ilio-femoral ligament. The annexed account comprises a succinct outline of the principal reported cases. In a majority of these the head of the femur was thrown downwards against some portion of the ischium; in one it was lodged in the perineum, and in one it was pushed upwards and inwards against the ilium, lying in the space between the two anterior spinous processes.

a. In a case observed by Mr. Robert Keate, the head of the bone lay close to, and on a level with, the tuberosity of the *ischium*, where it could be distinctly felt rolling about under the finger on moving the thigh, which was more than three inches longer than natural, much flexed upon the pelvis, and widely separated from the sound one. The leg was greatly bent, the foot much everted, and the large trochanter extremely sunk. By drawing the upper part of the femur outwards, and pressing the knee sharply inwards, the head of the bone returned to its proper place with a decided snap. Immediately afterwards, however, the limb could be elongated by slight traction, inducing the belief that a portion of the cartilaginous rim of the acetabulum had been broken off in the accident, which had been caused by the man falling from his horse into a deep, narrow ditch, the animal tumbling backwards upon him.

3. In a case described by Mr. Wormald, the head of the femur rested upon the upper part of the *tuberosity* of the ischium, above the quadratus muscle. The accident, caused by a leap from a third-story window, was attended with other injury, which soon proved fatal. The head of the bone was easily recognized in its new situation. The limb, considerably shortened and inverted, formed half a right angle with the body, and the shaft of the femur, crossing the pubic symphysis, was immovably fixed in this position.

γ. Mr. Earle and Mr. Adams have each recorded a case in which the head of the bone lay upon the *spine* of the ischium. In the former the limb was lengthened about half an inch, but there was neither eversion nor inversion; the trochanter was further back and less prominent than natural; an extraordinary vacuity existed in front of the hip; and the outline of the sartorius and tensor muscles was uncommonly distinct, their edges being tense and almost sharp. In Mr. Adams's case the limb was inverted, and could not be rotated outwards when the knee was extended, nor abducted when the knee was flexed. Slight shortening existed.

3. Dr. Kirkbride met with an instance in which the head of the femur was thrown upon the posterior part of the *body* of the ischium, between the tuberosity and the spine. The thigh lay across the sound one, the leg was flexed, the limb was lengthened at least an inch, and the interval between the great trochanter and the anterior superior spinous process of the ilium was much increased. Rotation was difficult, and extension impossible. The head of the bone was easily felt. The accident was caused by a fall from a considerable height, in which the body was crushed by a heavy piece of timber. The reduction was effected by the pulleys, but not without difficulty, for the man was very muscular, and the bone was firmly impacted in its new situation.

• In two cases seen by Dr. J. M. Warren the head of the bone rested against the

ascending *ramus* of the ischium, the thigh projecting out laterally at a right angle with the trunk. A deep hollow existed at the spot naturally occupied by the great trochanter. The reduction was effected, in one of the cases, by manipulation; in the other, by the pulleys.

5. Dr. Willard Parker has reported a case of dislocation of the femur into the *perineum*, in a man, thirty-five years of age, who was injured by the fall of a boat, his body being at the moment bent strongly forwards and his feet widely separated. The limb projected at a right angle with the trunk, the buttock being flattened, and the toes turned slightly inwards; and the head of the bone, upon rotating the thigh, could be distinctly felt in the perineum behind the scrotum, near the bulb of the urethra. The reduction was readily effected by confining the pelvis and extending downwards and outwards, aided by moderate rotation. In this way the head of the bone was made to ascend over the *ramus* of the pubes into the thyroid foramen, from which it was afterwards conducted into the acetabulum by carrying the limb across the sound one.

7. A case similar to the above occurred to Dr. Pope, of St. Louis, in a man, forty years of age, who had his body crushed by the caving in of a bank of earth, as he was standing in a bent position, with his limbs widely separated. The thigh, inclined somewhat forwards, formed a right angle with the body, and the head of the bone lay under the skin of the raphe of the perineum. The accident was associated with fracture of the leg and arm. Reduction was effected with the pulleys, the bone returning with a loud snap.

8. Several cases have been met with in which the head of the femur was dislocated upwards and inwards into the space between the two anterior *spinous processes*. In one, examined by Mr. Morgan, the bone, lying in this precise spot, could be distinctly felt under Poupart's ligament, upon the brim of the pelvis. The prominence of the great trochanter was entirely lost, the thigh was shortened at least two inches, the toes were excessively everted, and the injured limb had a tendency to cross the sound one. Rotation was impossible, but all the other motions could be performed, although only in a limited degree, and not without great pain. Reduction was easily effected. A similar case has been described by Mr. Travers: it was caused by a fall from a height of twenty feet, in which the left buttock struck upon a coil of chain cable. Here, however, the neck, and not the head of the bone, lay between the two anterior spinous processes, the head not being perceptible. The left buttock was flattened, and the limb, shortened and everted, had the appearance, when the patient stood erect, of being suspended from the anterior and lateral part of the ilium. A little below and to the outer side of this point was the great trochanter, easily distinguishable by the finger.

9. In a case described by Mr. Luke, the head of the bone was lodged midway between the thyroid foramen and the sciatic notch, immediately beneath the lower border of the acetabulum. The limb was lengthened one inch, without eversion or inversion, and the head of the bone was easily felt in its new position. The reduction was accomplished without difficulty. The man dying from the effects of other injuries, the dislocation was reproduced in the dissection of the joint. The inferior gemellus and square femoral had been torn, the lower part of the capsular ligament had given way, and the round ligament was completely detached. The patient, a stout man, fifty years of age, had been hurt by a fall into a dry-dock.

10. Finally, Dr. W. E. Hodder, of Toronto, has recorded the case of a man, twenty-two years of age, in which the head of the femur was thrown under the *arch of the pubes*, by a large quantity of earth falling upon the loins and hips. The bone could easily be distinguished in its abnormal position, and the thigh, as the patient stood up, formed nearly a right angle with the trunk. The knee was everted, a remarkable concavity existed upon the dorsum of the ilium, the *psoas* and *iliac* muscles were very tense, and the great trochanter could scarcely be felt. The affected limb was, if anything, a little longer than the sound one.

The above cases may be regarded as types of most, if not all, of the forms of anomalous dislocations of the hip-joint. The symptoms are usually prominent, if not positively characteristic. The treatment must be conducted according to the general principles which guide the surgeon in the management of the ordinary varieties of the accident. Manipulation alone will frequently suffice to effect reduction, as there is always necessarily extensive rupture of the soft parts; when greater force is required, the pulleys must be employed. In some of the cases here men-

tioned, the restoration was effected by a kind of compound process, the dislocation being first changed into a common one, from which the head of the bone was afterwards returned to its natural position by a secondary effort.

PARTIAL AND COMPLICATED DISLOCATIONS.

The possibility of a partial dislocation of the hip-joint is still a debated point. Malgaigne admits the possibility, and adduces cases in illustration of it. Professor Hamilton thinks he has met with two examples of it; and, many years ago, Dr. J. C. Warren saw one, in a child six years old, which has also been referred to this class of injuries. If we define, as in strictness of language we must, a partial dislocation to be one in which the articular surfaces of the joint still partly retain their natural relations, it is extremely questionable whether such an occurrence is possible, as a purely traumatic accident; as a result of disease of the head of the femur, of the borders of the acetabulum, or of the ilio-femoral ligaments, it is easy enough to admit it.

Dislocations of the hip-joint are sometimes complicated with fracture of the femur; the occurrence, however, is very uncommon, and is chiefly of interest in reference to the restoration of the parts, which should always, if possible, be effected by manipulation instead of by extension and counter-extension. Dr. James Douglas has reported a case of luxation upon the pubes, accompanied with fracture of the neck of the femur, the superior extremity of which was found after death, twelve years after the receipt of the injury, in the groin, on the inside of the femoral vessels. The head of the bone still remained in its natural position. The reduction of such a dislocation must necessarily, one would suppose, be attended with immense difficulty, and yet it would seem, from experiments performed by Richet upon the dead subject, that this is not the fact. He ascertained that, by luxating the femur and then dividing the neck of the bone, so as to imitate a fracture, he could easily push the head into its socket. When the femur is broken in its shaft, the limb, as a preliminary step, must be firmly put up in splints, otherwise it will be impossible to obtain a proper leverage for executing the requisite manipulations.

Dislocations of the hip-joint, complicated with fracture of the acetabulum, are always serious accidents. Cases have been reported in which the head of the bone was pushed through the bottom of this cavity into the pelvis, inflicting serious, if not fatal, injury upon its contents; and I have myself seen specimens, in different museums, where the floor of the acetabulum was broken into numerous fragments by violence sustained in this way. The upper rim of the acetabulum is occasionally chipped off by the head of the femur, especially in the iliac and sciatic forms of luxation, and, in such an event, it is always very difficult, if not impossible, to retain the parts in their natural relations after replacement. The best plan, after reduction, is to keep up permanent extension by means of a weight attached to the foot, and to support the affected joint with a broad belt passed around the pelvis.

CHRONIC DISLOCATIONS.

Chronic dislocations of the hip-joint are occasionally brought under the observation of the surgeon, and the question, therefore, necessarily arises, when should such displacements be considered as irreducible? It has been seen elsewhere that Sir Astley Cooper asserts that, as a general rule, it is imprudent to attempt restoration after the eighth week, except in persons of a debilitated frame, or very lax habit of body; and most English and American surgeons, adopting this view, have inculcated similar precepts. I believe this opinion to be in the main correct, and it may even be assumed that there are not a few cases which will resist all efforts at reduction long before the expiration of this period. In an especial manner is this true of the dislocations backwards into the sciatic notch and downwards into the thyroid foramen, in which the head of the femur becomes much sooner firmly and immovably fixed in its new position than in the iliac and pubic varieties. Sir Astley Cooper himself admits the existence of exceptions, and he has published the particulars of a case of luxation, upon the dorsum of the ilium, reduced after the lapse of five years. Numerous instances of a similar purport, only of much shorter duration, have been narrated by other writers, all tending to show that there are circumstances in which reduction may be hoped for after a joint has been out of place for several months.

It is not necessary to repeat here what has elsewhere been insisted upon in regard to the considerations which should influence the surgeon in the choice of his cases; or, in other words, the circumstances which should induce him to attempt or decline interference. Full instruction has already been given upon this subject, and yet, in view of its paramount importance, it may not be amiss to subjoin a few remarks, if it be only for the purpose of insuring greater care and caution.

The circumstances which may usually be considered as forbidding any efforts at restoration are, first, the absence of mobility in the luxated bone; secondly, occlusion of the acetabulum by fibrinous deposits; and, thirdly, great disorder of the general health, rendering it probable that the system could not withstand the shock and irritation following the operation.

The first of these points can usually be determined by moving the limb about in different directions, and watching the degree of displacement suffered by the femur. The examination should be conducted by taking hold of the knee, or, better still, of the knee and ankle, and it will be most efficient if, while the limb is rotated, or attempted to be rotated, the hand be applied to the head of the luxated femur. When there is no motion, or motion only in a limited degree, it may be assumed that the adhesions are too strong to admit of rupture without risk of serious injury to the parts.

It is not always, indeed not generally, easy to determine whether the acetabulum has been filled up or not by plastic deposits. The probability of such an occurrence may be inferred if the accident have been followed by severe inflammatory action, if the parts have ceased to be tender on pressure, and if the head of the bone have contracted firm adhesions to the surrounding tissues. If any doubt remain, the exploring needle might be used, its point being carried about in different directions, to ascertain the amount and consistence of the obstructing substance.

It may be stated that, other things being equal, the acetabulum will be filled up much sooner in young, robust subjects than in the aged and feeble, and that, as a general rule, the likelihood of its being so is always in proportion to the length of time that has elapsed since the occurrence of the displacement.

Finally, the patient's health may be so much reduced as imperatively to prohibit all attempts at reduction, not on account of any pain that might be experienced, for chloroform would effectually prevent that, but because so much violence might be done in the operation as to cause the most intense inflammation and constitutional irritation, placing life in imminent peril.

When it is deemed advisable to undertake the treatment of such cases, it will generally be necessary to use the pulleys, subject to the rules and regulations already laid down for their employment; but sometimes the object may readily be attained, or, at all events, without much difficulty, simply by manipulation. Thus, Dr. Dupierris, of Havana, and Dr. Blackman, of Cincinnati, each met with an instance of iliac luxation of six months' standing, in which they succeeded most satisfactorily by this method alone; and a number of similar cases have occurred in the practice of other surgeons. Dr. Sayre effected the reduction of a sciatic luxation by manipulation at the end of nine months; and Dr. Smyth, of New Orleans, was equally fortunate in a case of the iliac form of the accident at the end of this period. Such examples are full of instruction, and deserving of the most attentive consideration, conveying, as they do, a highly valuable practical lesson. Nevertheless, they must be regarded merely as so many exceptions to a general rule, and nothing more.

Finally, instances have occurred, as those observed by Physick, Travers, Randolph, Malgaigne, Blackman, Wood, and Prince, in which, in an attempt to reduce an old dislocation of the hip-joint, the femur gave way at its neck, within the capsular ligament. Sometimes violent inflammation, abscess, and even pyemia have followed the accident; and several examples have been recorded in which the patients lost their lives. Occasionally a more fortunate result ensues, the fracture of the bone being eventually succeeded by a good use of the limb, as in the case of a man between thirty-five and forty years of age, whom I attended along with my colleague, Professor Pancoast. The head of the femur lay upon the iliac bone, the displacement having occurred nearly three months previously. There was great lameness, accompanied with much deformity, and, as the patient was very anxious for relief, he was accordingly chloroformed and subjected to the use of the pulleys, as well as to manipulation. During the progress of our efforts, the bone suddenly broke at its neck, and the result was a very good use of the limb, the patient being able in a

few weeks to move it in every direction, instead of being obliged to hold it in the stiff and unseemly position in which it had been previously. The shortening did not exceed two inches.

Although it might not be advisable to adopt such a procedure as this as a rule of practice, it is worthy of consideration whether, in cases of irreducible dislocations, attended with great deformity, and a useless condition of the limb, it would not be proper. The patient here alluded to experienced no serious inconvenience from the accident, and the result was certainly highly gratifying. It is to be borne in mind that, from the softening which the articular extremities of the bones undergo in old and neglected luxations, such a fracture is a comparatively easy and simple occurrence, not necessarily followed by severe inflammation. Without such an effort, it is evident that the patient must remain a cripple for life.

CONGENITAL DISLOCATIONS.

Congenital luxation of the hip-joint is very uncommon. Females are more liable to it than males, and it is also more frequent in scrofulous than in healthy children. Of forty-five cases reported by Dupuytren and Pravaz, only seven were males; a disproportion which it is impossible to suppose to have been altogether accidental. The immediate causes of this variety of displacement are, first, shortness, total absence, or extreme obliquity of the neck of the thigh-bone; secondly, partial or entire obliteration of the cotyloid cavity; and, thirdly, deficiency, extraordinary elongation, or complete absence of the round ligament.

The malformation consists in shortening of the affected limb, unnatural projection of the great trochanter, ascent of the head of the femur into the iliac fossa, inversion of the leg, and obliquity of the pelvis. The motions of the joint, particularly those of abduction and rotation, are constrained and imperfect; the muscles of the upper part of the thigh are retracted, or drawn towards the iliac crest; the limb is thin, wasted, and out of all proportion to the rest of the body; the tuberosity of the ischium is almost uncovered, and, consequently, unusually prominent; the upper part of the trunk is thrown backwards, while the lumbar portion of the spine projects forwards, being concave behind; the pubes is placed almost horizontally on the thighs; and the ball of the foot alone touches the ground when the child stands erect.

In the recumbent posture, when the weight of the trunk is taken off, and the muscles are relaxed, most of the symptoms of luxation disappear, and the limb may be shortened or elongated at pleasure. In walking, the body is inclined towards the sound side, and the head of the dislocated bone sinks towards the cotyloid cavity by its own weight. As age advances, the limb becomes shorter, the femur ascending higher and higher on the ilium; the obliquity of the pelvis augments; and the power of locomotion, already so much impaired, is completely destroyed.

Congenital dislocation of the hip-joint may generally be easily distinguished from other accidents or maladies, by the affection being observed at or soon after birth; by the obliquity of one or both thighs; by the absence of pain, swelling, and ulceration; by the head of the femur being displaced without any external violence; and by the ability of the surgeon to lengthen or shorten the limb at pleasure. In disease of the hip there is always more or less pain, with a feverish state of the system, and gradual failure of the strength; the parts about the joint are tense and swollen; the limb, at first somewhat lengthened, becomes afterwards shortened, and cannot be extended without the greatest suffering; and the motions of the ilio-femoral articulation are permanently impaired.

The pathological appearances vary. In general, the cotyloid cavity is partially obliterated, or entirely deficient, being replaced by a small, irregular osseous prominence, devoid of cartilage and synovial membrane; the head of the femur, often flattened at its antero-internal aspect, rests in a kind of superficial fossa on the dorsal surface of the ilium; the round ligament is elongated, partially worn away, or even altogether absent; and the surrounding muscles are either atrophied, transformed into a yellowish, fatty, fibrous tissue, or preternaturally developed. In the latter case, their action is preserved; in the former, it is very much restricted, if not totally abolished.

The treatment of congenital dislocation of the hip-joint can seldom be anything more than palliative. In cases of recent standing, permanent extension, by means of a common fracture apparatus, or some other suitable contrivance, may be tried

with a prospect of advantage. When both joints are involved, the patient should be kept for a long time in the recumbent posture, in order to take off the weight of the body from the limbs, as this is the main agent in aggravating the displacement. As an important auxiliary measure, the shower-bath, followed by dry friction, or friction with ammoniated and other stimulating liniments, may be employed. The pelvis may be encircled with a broad, well-padded belt, so as to steady the trochanters, and counteract the tendency of the thigh-bones to ascend towards the iliac crests. If debility exist, tonics will be required, especially quinine and some of the preparations of iron.

CHAPTER II.

INJURIES AND DISEASES OF THE HEAD.

INJURIES of the head have always been objects of the deepest interest and study with the surgeon. Independently of the frequency of their occurrence, they merit the greatest attention, on account of the obscurity of their diagnosis, the stealthy character of their progress, the difficulty of their management, and the uncertainty of their termination. It was long ago remarked by Mr. Pott, and the observation has been verified a thousand times since, that there is no lesion of the head so trifling, on the one hand, as not to endanger life, or so severe, on the other, that it may not be followed by recovery.

SECT. I.—LESIONS OF THE SCALP.

1. WOUNDS AND CONTUSIONS.

Wounds of the scalp exhibit the same general features as wounds in other regions. The only actual difference is their great liability to be followed by erysipelas, neuralgia, arachnitis, cerebritis, and various other secondary affections.

Incised Wounds, of whatever extent or depth, should always be treated with reference to the production of immediate reunion. With this view, as soon as they have been divested of blood and foreign matter, their edges should be neatly approximated with a suitable number of twisted sutures, the threads being carried from one pin to another, so as to obviate the necessity for the application of adhesive plaster. When the cut is very slight, contact may often be effectually maintained by tying together at their base a few little locks of hair on each side of it; the threads should be very fine, and well waxed, otherwise it will be difficult for them to retain their hold until the adhesive process is sufficiently advanced to admit of their removal. When the wound is very large, the scalp should always be well shaved, as a preliminary step, but under opposite conditions such a precaution will generally be entirely unnecessary.

It is difficult, at this day, to conceive why so much opposition should have been made in former times to the use of sutures in wounds of the scalp. In reading the accounts of some of the older surgeons of this mode of treatment, one is almost tempted to conclude that they must have thought that there was something peculiarly poisonous in it; a violent war was waged against it for nearly half a century, and it is questionable whether its influence has yet altogether disappeared. However this may be, it cannot be doubted that sutures of the scalp, in whatever form they may be used, are as harmless as any mode of dressing of which it is possible to form any conception. If they were formerly a source of irritation, a circumstance which can hardly be denied, the occurrence was in all probability due to the coarseness of their material, and the manner of their introduction. These objections certainly do not exist at the present day, and no one who has once tried them in this situation will ever be likely to dispense with them. These remarks are particularly applicable to the twisted suture, which, in addition to the benefit already ascribed to it, has the advantage of compressing the orifices of the divided vessels, and of thus effectually controlling hemorrhage. I have repeatedly seen the edges of a wound

in the scalp, approximated simply with adhesive plaster, forced apart, and prevented from uniting, by the interposition of coagulated blood. When the twisted suture is properly made, no other dressing whatever is needed; the part is constantly exposed to view, and the moment any untoward change arises it is detected, which it cannot be when the ordinary retentive means are employed. The pins should not be withdrawn before the fourth or fifth day. The best material for the interrupted suture is silver wire.

Lacerated Wounds of the scalp are generally caused by blows or falls on the head, or by the passage of the wheel of a carriage. One of the most severe and extensive injuries of this kind that I have ever witnessed was inflicted by the horns of an infuriated cow. Owing to the manner in which they are produced, more or less foreign matter is usually entangled in these wounds, and, for the same reason, they are often followed by violent inflammation, suppuration, and even gangrene. The rule of treatment is the same as in incised wounds, but special care should be taken not to draw the edges so firmly together, lest the resulting swelling, which will always be considerable, should induce undue tension, and thus necessitate the premature detachment of the sutures. The scalp, too, should always be extensively shaved, and cold water-dressing freely used, to prevent the untoward occurrences adverted to. With proper attention, it is surprising how much of the wound may, even in apparently the most unpromising cases, unite by the first intention.

The scalp is sometimes very seriously injured by machinery in rapid motion, as in a remarkable case which I attended in 1869, with Dr. Alfred Jones, of this city, in a woman, twenty-two years old, who, in consequence of having her hair caught by a revolving shaft in a macaroni factory, had her scalp completely torn off, along with one of the eyebrows. Although the immense flap was replaced within half an hour after the receipt of the injury, and most accurately stitched on by sutures, no union whatever occurred, and eighteen months elapsed before the surface was completely cicatrized. The woman, for some hours, labored under severe shock; and, although she was at the time three months advanced in pregnancy, she carried her child to the full term. There were numerous exfoliations of thin plates of bone over the entire head, beginning several months after the accident. No cerebral symptoms were at any time present.

Punctured Wounds of the scalp, apart from their tendency to erysipelas and suppuration, are usually very simple accidents. The proper remedy is cold water-dressing, simple or medicated, conjoined, if inflammation run high, with the application of leeches, and emollient poultices. If matter form, or even if there be merely severe tension, appropriate incisions should promptly be made.

In *Contused Wounds*, the rule is, after thorough shaving of the scalp, and the removal of foreign matter, to approximate the edges very lightly with the interrupted suture. Proper allowance is made at the start for swelling and tension, which are often severe. If the edges are shreddy, or tattered, they are neatly trimmed with the scissors, but on no account should any flaps, even if violently bruised and apparently dead, be cut off; for no one can positively determine, beforehand, whether such a part is really deprived of vitality or not, and it is best, therefore, always to afford nature an opportunity of saving all she can. The leading indication is to circumscribe inflammation, the best remedy for the purpose being the warm water-dressing, rendered slightly stimulating by the addition of a small quantity of laudanum, alcohol, or spirit of camphor. The object is to impart tone to the contused vessels and nerves, to enable them the more readily to withstand the effects of inordinate action. Pencilling the surface immediately around the wound with a weak solution of iodine or nitrate of silver is sometimes beneficial.

Contusions, properly so termed, of the scalp, occur in various degrees, from the slightest bruise to a mashed, softened, and pulpified condition of its component elements. They may be superficial or deep-seated, circumscribed or diffused, simple or complicated. Their tendency, even when slight, is to run into violent inflammation, especially the erysipelatous variety, followed by abscess, and even gangrene. Such events will, of course, be most likely to happen in persons of intemperate habits, or of a broken constitution, though the most healthy individuals do not always, indeed, perhaps, not generally, escape them. Another effect of a severe contusion of the scalp is its liability to produce mischief in the brain and its membranes. Two circumstances suggest themselves as likely to bring about this condition. The first is the shock sustained by the cranial contents by the violence of the blow

inflicting the contusion, and the other, the disposition in the resulting inflammation to extend to the meninges through the vessels and fibres of the pericranium. Accidents of this kind are occasionally complicated with fracture of the skull, detachment of the dura mater, or concussion of the brain. Sometimes, again, a portion of bone is merely bruised, and yet the action consequent upon the lesion is so great as ultimately to cause its death. When the contusion is at all severe, there is usually a considerable effusion of blood, presenting itself generally in the form of a circumscribed tumor; in rare cases the blood is widely diffused, extending, in fact, nearly over the whole head.

Contusions of the scalp, however slight, should always be regarded as accidents of grave import. The patient should be cautioned about his diet; the bowels should be properly regulated, and premature exposure should be carefully guarded against. Under this management, the affected parts will generally be speedily restored to their pristine condition, without, perhaps, the slightest topical medication, except the use of cold water, or some mildly astringent lotion. When the injury is more extensive, warm water-dressing should be used, with the addition of opium and hydrochlorate of ammonia, acetate of lead, alcohol, or spirit of camphor. These ingredients are particularly valuable in such cases, not only by imparting tone to the affected tissues, but by promoting the absorption of extravasated blood. Warm applications are nearly always borne better, both by the scalp and the system at large, than cold, whether simple or medicated, and they are also much less likely to cause injurious metastasis to the brain and its membranes. In regard to this matter, however, the surgeon will always do well to consult the feelings of his patient. When the inflammation is at all severe, leeches will be demanded, especially if there be impending cerebral involvement, and they should be profusely scattered over the affected surface. Tension and swelling are relieved by multiple punctures, while abscesses must be opened, early and freely, to assuage pain and prevent the diffusion of pus.

Wounds and contusions of the scalp are often followed by serious secondary effects, consisting, for the most part, of certain nervous symptoms, as numbness of the scalp, partial paralysis of the face, headache, muscular twitchings, strabismus, and neuralgic pains. Occasionally the scalp remains very tender at one particular spot, perhaps not larger than half a dime, so that the individual is unable to bear the slightest pressure of the finger, or even of his hat. At times, again, these injuries are followed by epilepsy, abscess of the liver, and atrophy of the testes.

The treatment of these secondary effects must be by incision, and by protracted pyogenic counter-irritation, more especially when there is great tenderness, of a circumscribed character, depending upon chronic thickening of the periosteum; by antineuralgic remedies, when the pain is periodical, or of a dull, heavy, aching character; and by emetics, purgatives, and a properly regulated diet, when there is disorder of the digestive organs, with irregular action of the muscles. The cold shower-bath, change of air, and, in obstinate cases, slight but persistent ptyalism, will be beneficial.

2. ABSCESSSES.

Matter is liable to form upon the head in three different situations, in the subcutaneous cellular tissue of the scalp, below the occipito-frontal muscle, and between the pericranium and the skull. Most generally it occurs in the first of these localities; least frequently in the last. The most common exciting cause is external injury, as a wound, blow, fall, or contusion. Sometimes the abscess arises spontaneously, but in the majority of cases, whatever may be the provocation, its formation is preceded and accompanied by erysipelatous inflammation, denotive of disorder of the general health, or of a vitiated condition of the secretions.

The symptoms are generally well marked. The pain is severe, and of a throbbing, burning character; the swelling, which is either circumscribed or diffused, pits on pressure; and the surface presents an erysipelatous appearance. The concomitant inflammation often extends from the scalp to the eyelids and face, temples, ears, and nape of the neck. The constitutional involvement is generally considerable, not unfrequently running into delirium at an early stage of the attack, especially when the pus is situated beneath the pericranium. Violent rigors sometimes mark the progress of the case.

The quantity of matter varies from a few drachms to several ounces. In a case which I recently attended in a child, eleven years of age, there was nearly half a pint of fluid, of a thick, cream-like consistence. The abscess was situated on the vertex, forming an immense projection under the detached and attenuated scalp.

The sensation which an abscess in this situation imparts to the finger is peculiar, particularly if some time has elapsed since its development. While the abscess itself freely fluctuates, and perhaps forms a pendulous bag, the base is generally remarkably hard, sharp, and precipitous, evidently from plastic deposits, feeling precisely as if it consisted of the rim of a depressed fracture. This feature is commonly so distinct, in circumscribed abscess of the scalp, that the surgeon, unless fully upon his guard, will be very likely to be deceived in respect to the true nature of the case. In diffused collections the base is less abrupt, and, therefore, the danger of mistake is not so great.

When the pus lies beneath the aponeurosis of the occipito-frontal muscle, it is generally very slow in reaching the surface, and, consequently, often causes great mischief by its extensive diffusion, dissecting the parts freely from their natural relations, and forming a large, boggy, purulent bag, with a more or less well-defined boundary. An abscess beneath the pericranium, or between it and the skull, usually occurs as a small, puffy, circumscribed swelling, accompanied with excessive pain and tenderness; it generally follows upon a severe contusion, wound, or fracture, a number of days—not unfrequently as many as ten, twelve, or fourteen—after the accident, and is extremely liable to give rise to caries, if not also to necrosis, of the cranial bones, and inflammation of the brain and its membranes, from the destruction of the connecting vessels and the extension of the morbid action. If the patient die, pus, as stated under the head of pericranitis, will probably be found beneath the dura mater, which is at the same time more or less extensively separated from the bone, and in an unhealthy, sloughy condition. Such an abscess is always peculiarly dangerous, from its tendency to produce cerebral complications.

The *treatment* of these abscesses must be strictly antiphlogistic. Leeches, poultices, and water-dressings, medicated with acetate of lead and opium, are more particularly indicated in the earlier stages of the disease, along with the use of purgatives, attention to the secretions, and a proper regulation of the diet. The moment fluctuation is perceived, or even before, if there be much tension, free incisions should be made. Cerebral symptoms are combated in the usual manner. If matter form beneath the skull, as indicated by the whitish or yellowish aspect of the bone, and disturbance of the brain, the trephine should be employed, although such an expedient will seldom be followed by any permanent benefit.

3. TUMORS.

a. Sanguineous Tumors.—Sanguineous effusions are often met with on the scalp, generally as a consequence of blows, falls, kicks, and other injuries, the blood being extravasated into the subcutaneous cellular tissue, either in the form of a distinct swelling, or as an infiltration. The accident not unfrequently happens during parturition, from the pressure on the child's head in its descent through the soft parts of the mother, giving rise to a tumor, termed by Nægele and other writers, cephalæmatoma. Contusions of the scalp, however slight, or however induced, are always followed by such an occurrence. The blood may be situated immediately beneath the skin, below the aponeurosis of the occipito-frontal muscle, or beneath the pericranium, in direct contact with the bone. Varying in quantity from a few drachms to several ounces, it is of a fluid, semifluid, or solid consistence, and of a dark purple color, according to the period at which it is examined, or the circumstances under which it is extravasated. The most abundant accumulations of this kind usually occur at the sides of the head and the superior part of the occiput, in consequence, apparently, of the greater laxity and vascularity of the tissues there than elsewhere. Immense bags of blood are occasionally formed in both these situations, especially after falls and blows on the head, attended with the laceration of some of the branches of the temporal and occipital arteries.

When the tissues of the scalp have been much contused, the extravasated blood is seldom completely coagulated, and it may even remain perfectly fluid, having apparently been devitalized at the moment of the accident. The same thing usually occurs when the collection is very large, although the parts may have suffered com-

paratively little violence. If the blood be retained for any length of time, it undergoes changes similar to those witnessed in an apoplectic effusion; it loses its dark color and soft consistence, and is converted into a grayish, fibrinous mass, of varying firmness and density. On the other hand, the solid matter is occasionally completely absorbed, all that remains being a pale, serous, or oily-looking fluid. During the inflammation which supervenes upon the accident, pus is sometimes poured out, and, mingling with the blood, imparts to it its peculiar appearance.

The tumor formed by the extravasated blood is either circumscribed and of a rounded or conical shape, or it is diffused and irregular, being, perhaps, flattened at one point and elevated at another. It is always soft and fluctuating at the beginning, and sometimes it even retains this feature throughout, although in most cases it soon becomes comparatively hard and firm, from the coagulation of its contents. When it is caused by external violence, as a blow or fall, it has occasionally a sharp, abrupt, and well-defined margin, and the finger, as it sinks into the centre of the swelling, receives an impression as if there were a fracture of the skull with depression of the bone, although nothing of the kind is present. The appearance of the skin is variable; generally it is unchanged, being neither discolored, ecchymosed, nor œdematous. When inflammation arises, the tumor becomes hot, tender, and painful. In cases of long standing, the blood is sometimes surrounded by a distinct cyst, and, in the subpericranial form of the affection, the uplifted membrane has been known to undergo extensive ossification.

Accumulations of blood of the scalp, whether circumscribed or diffused, usually disappear either spontaneously, or under very simple treatment, as refrigerant, astringent, and sorbefacient lotions, tincture of iodine, blisters, and leeches, the two latter being particularly indicated when the tumor is hot and inflamed. The most efficacious remedy will be found to be a strong solution of hydrochlorate of ammonia, as an ounce of the salt to a quart of water, with the addition of a little vinegar. Mild purgatives will often be useful, and proper attention must be paid to the diet. When the case proves troublesome, as it may when the blood is unusually profuse, deep-seated, or deprived of vitality, subcutaneous evacuation, followed by systematic compression, will be necessary.

β. *Sebaceous Tumors*.—The most common of the tumors of the scalp are the sebaceous, which often exist in considerable numbers, and which are always easily diagnosticated, their tardy development, their semisolid consistence, their great mobility, and the sparsity or entire absence of hair on their surface, being generally sufficiently characteristic of their true nature. Their size ranges from a pea to that of a small orange. Sometimes they are solitary, but more frequently multiple; and I recollect one instance, in a middle-aged man, in which there were upwards of two hundred, many of them of considerable bulk. Examples have come under my observation in which two and even three tumors were inclosed in one cyst. Occasionally they are hereditary, and I have seen a number of cases in which they were traceable through several successive generations. Their contents are generally of a semisolid, suety consistence, and of a whitish appearance, or of the consistence and color of honey. The cyst varies much in character; generally, however, it is thick, whitish, dense, and firm, with a smooth, glistening inner surface. In very old cases, especially when the morbid growth has been long subjected to pressure, it is of a fibro-cartilaginous nature, or even partially ossified, and proportionately thick and strong. The adhesions then, between the tumor and the skin, are also unusually firm.

The sebaceous tumor of the scalp occasionally inflames, suppurates, or even ulcerates, its contents, in such an event, being generally excessively fetid, from the contact of the air.

The congenital form of this tumor frequently contains hairs, especially when it occupies the region of the eyebrows; and cases occur in which, apparently by its pressure, it indents the skull, causing marked depression in the outer table, if not actual perforation of the inner; attended, perhaps, with perceptible pulsation of the brain beneath.

The treatment of this variety of tumor is by incision and enucleation, the latter of which is always very easy when there are no firm adhesions. When the tumor is very large, or ulcerated, an elliptical incision will be necessary, to include redundant or diseased integument. A few little arteries occasionally require ligation. The edges of the wound are closed with sutures, either interrupted or twisted, the latter in preference, especially if there be much of a gap or marked disposition to bleeding. The

chief danger after the operation is erysipelas, which must, of course, be carefully guarded against. Such an occurrence is more particularly liable to happen when the tumor is situated in the lower part of the occipital region.

γ. *Cystic Tumors*.—A cystic tumor, generally congenital, sometimes occurs on the head, either beneath the aponeurosis of the occipito-frontal muscle, or in the substance of the scalp. It is filled with serous fluid, fluctuates on pressure, and is seldom larger than a pigeon's egg or an almond. In some instances it is multilocular, or composed of a congeries of cysts, closely grouped together. The remedy is extirpation.

A singular case of *dermoid cystic tumor* of the scalp filled with a fluid which had all the properties of that of hydrorachitis, is recorded by Giraldès, in his Clinical Lectures. It lay directly over the anterior fontanelle, and bore so close a resemblance to a meningocele that it was for a long time supposed to be of that nature. After repeated but unsuccessful efforts at cure by puncture and compression, the tumor was at length exposed by a free dissection, and its contents turned out, when it was discovered that there was no communication whatever with the cranial cavity.

δ. *Elephantiasis*.—Hypertrophy of the scalp, better known as elephantiasis, is a very uncommon affection, most generally situated at the lower and back part of the head, where it sometimes forms a large, unsightly mass, of the volume of a large fist, transversely rugated, and of a semielastic consistence. It is perfectly indolent, and the only inconvenience which it occasions arises from its bulk and deformity. Its origin is invariably congenital. Thirion has published several cases in which he succeeded in effecting a cure by the joint agency of compression and the application of iodine; but when the mass is uncommonly large, the best plan is to excise it.

ε. *Fatty Tumors*.—Lipoma of the scalp is very uncommon, and seldom attains any great bulk. As in other regions, it is of tardy growth, painless, and not always easily distinguishable from sebaceous and fibroid formations. In a case of fatty tumor of the scalp, reported by Dr. Cabot, of Boston, there was a fluctuating feel, with an appearance of translucency, resembling a cyst filled with blood. The chief question, as it respects the diagnosis in such a case, would be between an encephalocele and an oil cyst.

ζ. *Fibrous Tumors*.—A fibrous tumor is sometimes met with in this situation. Such a growth, removed by Professor Pancoast at the Clinic of the Jefferson Medical College, in 1858, by means of the *écraseur*, is represented in fig. 70. The patient was an elderly man; and the tumor, which occupied the vertex, and was of the volume of a large orange, had been of several years' standing. Its summit had been invaded by ulceration.

η. *Vascular Tumors*.—Different kinds of vascular tumors, arterial, venous, arterio-venous, and nævoid, sometimes occur on the scalp, and may in time acquire a large bulk and a formidable character. Their diagnosis is easily determined by their history, their congenital origin, their reddish, bluish, or purplish color, their soft consistence, their freedom from pain, their mobility, and their erectility when the patient laughs, cries, or sneezes. The arterial growth, the anastomotic aneurism of John Bell, is particularly liable to expand under mental emotion, and nearly always pulsates synchronously with the heart. Vascular tumors of the scalp sometimes ulcerate, and thus give rise to hemorrhage, the frequent repetition of which may eventually prove fatal.

Riddance should be effected as early as possible. The best remedies are the knife, ligature, or twisted suture, composed of two strong pins inserted at right angles. The knife is applicable only when the tumor is very small, and of a venous structure. Whatever procedure be adopted, the rule is to include every particle of the morbid growth, otherwise there will inevitably be a certain amount of repullulation. When the tumor is seated over the anterior fontanel, great care must be taken not to

Fig. 70.



Fibrous Tumor of the Scalp.

wound the membranes of the brain, as might readily happen, from their close proximity to the scalp, in the hands of an incautious operator.

Fig. 71.



Malignant Ulcer of the Scalp.

e. Malignant Tumors.—Malignant tumors of the scalp are infrequent. The most common form is the epithelial, or exedent lupus, which, usually beginning as a warty excrescence or small shot-like tubercle, in its progress occasionally involves the cranial bones. The resulting ulcer, fig. 71, is characteristic, having a foul, unhealthy aspect, and being the seat of a sanious, fetid discharge. The only remedy is early and free excision.

Surgical interference in tumors of the scalp should never be attempted without due preparation of the system, as it is extremely liable to be followed by erysipelas and other bad effects, imperilling life.

SECT. II.—AFFECTIONS OF THE CRANIAL BONES AND THEIR APPENDAGES.

1. PERICRANITIS.

The pericranium, like the periosteum everywhere else, is liable to inflammation and its consequences, and the disease, especially in its acute form, is particularly worthy of study, from its liability to involve the brain and its envelops. The exciting causes are various. Among the more common are external injury, as blows, wounds and contusions, sudden suppression of the cutaneous perspiration, and a syphilitic taint of the system. Not unfrequently the affection arises without any assignable provocation, and cases occasionally occur in which it is propagated from the face, neck, nose, or orbit of the eye. Gout sometimes attacks the pericranium. The inflammation may be circumscribed or diffused.

The disease, in its milder forms, is originally characterized simply by pain and tenderness of the scalp, which gradually augment until, in many cases, they amount to great agony. The swelling is circumscribed, pits slightly on pressure, and has a peculiar shining, glossy appearance. Very frequently the whole scalp feels sore, numb, and heavy. The patient complains of headache, the system is feverish, the appetite is disordered, the secretions are vitiated, the bowels are costive, and the sleep is disturbed by unpleasant dreams. If the disease be not checked, all the symptoms, local and constitutional, increase in severity, the mind wanders, matter forms beneath the pericranium, and the scalp is suffused with an erysipelatous blush.

Diffused pericranitis is only a more aggravated form of the circumscribed. The inflammation is either violent from the beginning, or it soon becomes so; it spreads rapidly, and is accompanied by great pain and swelling, with a tendency to pass very speedily into suppuration. The patient is often delirious within the first few hours from the attack; the cephalalgia is agonizing, and is increased by every movement of the head, which feels like a heavy load; there is great intolerance of light and noise; the pulse is hard, frequent, and irregular; and rigors, alternating with flushes of heat, and followed by copious sweats, announce, at no distant period, the formation of pus under the pericranium and the extension of the disease to the dura mater, if not also to the brain and the arachnoid membrane. Such attacks are of the gravest character, and are almost sure, if not soon arrested, to prove fatal, death being preceded by coma, paralysis, and convulsions.

Dissection always affords evidence of great structural lesion. The scalp at the focus of the morbid action is soft, boggy, œdematous, and of a purple hue; the pericranium is extensively detached, thickened, spongy, vascular, and infiltrated; pus of a foul, unhealthy character lies in large quantity in immediate contact with the bone; the bone itself, of a whitish, grayish color, is partially devitalized and emits a peculiar ringing noise on percussion with a hammer; the diploë is highly congested, perhaps here and there ecchymotic and infiltrated with pus; the dura mater is separated and bathed in purulent fluid; and the arachnoid membrane is coated with pus and lymph. In the worst cases the ventricles of the brain are distended with serum, and even the brain itself may be implicated in the morbid action.

The *treatment* of pericranitis is sufficiently evident. In the milder forms, leeches, iodine, and saturnine lotions, assisted by active purgation, generally suffice to effect

the morbid action, and prevent serious mischief. When the disease is widely diffused, it will be necessary, in addition to these means, to make early and free incisions, extending down to the bone, to relieve tension, to give vent to effused fluids, and to protect the brain and its envelops. There must be no temporizing; the case is urgent, and the treatment must be correspondingly vigorous. The sac of the abscess may often be advantageously washed out with lotions of permanganate of potassa, nitric acid, or chlorinated soda, to promote healthy action.

In syphilitic perieranitis, which is generally associated with osteitis, and which, in its worst phases, nearly always occurs in the form of nodes or circumscribed swellings, the chief reliance must be placed upon the exhibition of the iodides with bichloride of mercury, and the application of leeches, iodine, and blisters. The knife is seldom required to let out matter, as this commonly disappears through the agency of the absorbent vessels.

2. CARIES, NECROSIS, AND FISTULE.

Caries of the skull, fig. 72, is usually the result of a constitutional taint, and sometimes attacks every bone, completely riddling both tables, and causing the most frightful suffering; the scalp is studded with ulcers, the discharge is foul and fetid, and the general health is sadly undermined. The affected bone often perishes, seldom, however, in its entire thickness, the external table being much more frequently involved than the internal. The treatment must be in strict conformity with the nature of the exciting cause. Great attention must be paid to cleanliness, fetor is allayed with the chlorides, and dead bone is removed as soon as it is sufficiently detached.

Caries and necrosis of the cranium from ordinary causes are uncommon. Serious mischief of this kind may arise from a simple blow upon the head, with or without scalp-wound, provoking inflammation and suppuration of the pericranium, which, becoming detached, occasions destruction of the osseous tissue. The effect may be limited or diffused, attacking one or both tables of the bones, and sometimes, although very rarely, involving almost the entire calvaria, as in the remarkable case of Saviard, in which, two years after a blow on the head, the whole skull-cap came away in one mass.

Frightful injury is sometimes inflicted upon the cranium in *burns*, from the accidental fall of the patient into the fire during an attack of epilepsy or a fit of drunkenness. In a case of this kind, under my observation, in 1860, in a man upwards of fifty years of age, the whole skull-cap had been completely detached some time previously, and its place occupied by a new shell of bone, covered with beautiful granulations, bathed in thick, healthy pus. The parts were progressing favorably under simple dressings, the man being in other respects perfectly well.

Injury inflicted upon the diploë, in which this substance is more or less severely bruised, shaken, or disorganized, is liable to be followed by grave inflammation, acute or chronic, eventuating in the formation of pus, either in its own structure, beneath the pericranium, or between the dura mater and skull, considerable portions of which sometimes perish from the destruction of their vascular connections. The matter that is found in this condition in the veins of the diploë is extremely liable to enter the circulation, thus becoming a direct cause of pyæmia, often attended with the development of embolic abscesses in the lungs, liver, and other organs.

Treatment of these affections is to be conducted upon strictly antiphlogistic copious leeching, vesication, and free incisions being among the more

Fig. 72.



Syphilitic Caries of the Skull; at a the Bone is Necrosed.

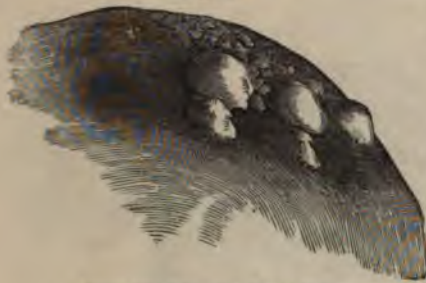
important measures. Matter must be promptly evacuated, and dead bone removed as soon as it is sufficiently loose. The brain and its membranes are carefully watched, that they may not suffer from secondary involvement.

The cranium may be affected with *fistule*, as a result either of injury or of organic disease. The nature of the lesion is generally easily detected with the probe; or, when this fails, by filling the passage with water, and then, while the opening in the integument is made the most elevated point, requesting the patient to take a deep inspiration. The water, if a fistule really exist in the bone, will now disappear, but will immediately be expelled during forced expiration. The cure of the disease is based essentially upon the removal of the exciting cause.

3. BENIGN TUMORS.

a. Exostosis and Hypertrophy.—The cranial bones now and then suffer from exostosis, of which there are two distinct kinds, the ordinary and the syphilitic. The former, which is often caused by external injury, is most common about the forehead, and may, in time, acquire a considerable bulk, although in general it is small. Its

Fig. 73.



Ivory-like Exostoses of the Skull.

structure is either comparatively soft and spongy, or hard and dense, like ivory. It seldom extends beyond the outer table of the skull, and has usually a tolerably broad base. Occasionally several such growths occur on the same bone, as seen in fig. 73.

When the exostosis extends inwards, or grows from the inner surface of the cranium, inducing neuralgia or epilepsy, and the diagnosis is sufficiently obvious, the offending structure should be removed with the trephine.

An exostosis of the skull is sometimes detached spontaneously, especially if it has a narrow, fibro-cartilaginous base, by being assailed by inflammation, gradually terminating in ulceration, or ulceration and gangrene, of the connective structures. Such an event, however, is very uncommon, on which account operative interference is generally the only resource. A great deal has been written about the danger of excision of such a growth, and some authors have even gone so far as to declare that removal should never be attempted so long as it does not give rise to serious suffering or inconvenience. Instead of the saw, gouge, chisel, and mallet, they insist upon the use of caustics, on the ground that there will be less danger of intracranial mischief. I cannot share these apprehensions. I have repeatedly employed excision, and have never had any cause to regret it. It may readily be supposed that such an operation, carelessly performed, might be followed by serious, if not fatal, disease of the brain and its membranes, especially when the tumor has an unusually broad base; but even in such an event the risk will be greatly diminished if there be no direct interference with the cranial bones.

Fig. 74.



Syphilitic Exostosis of the Skull.

The *syphilitic* form of exostosis is occasionally met with as a tertiary symptom, being most common in persons whose system has been injured by the conjoined effects

of the syphilitic poison and of mercury. The forehead is the most common site of the morbid growth, which is often multiple, and not unfrequently appears between the tables of the cranial bones. Its base is broad or diffused; its structure soft and porous. The disease is always accompanied by tenderness on pressure, and by fixed pain, liable to nocturnal exacerbations, which, together with the history of the case, generally readily distinguish it from the ordinary affection. When a tumor of this kind forms on the inner surface of the skull, it must necessarily cause more or less cerebral disturbance. The treatment is similar to that of tertiary syphilis in other parts of the body. The annexed sketches, figs. 74 and 75, exhibit the central and peripheral varieties of these formations.



Fig. 75.
Syphilitic Exostosis of the Inner Surface of the Skull.

A species of general *hypertrophy* of the bones of the skull sometimes occurs, either as the result of external injury, as a blow on the head, or, as more frequently happens, as an effect of the syphilitic virus. It is characterized by extraordinary density of structure, by complete effacement of the diploë, and by great increase of weight and thickness of substance. The treatment must be regulated according to the nature of the exciting cause.

3. *Venous Tumors*.—A peculiar form of venous tumor, communicating, through one or more openings in the skull, with the superior longitudinal sinus, has been described within the past fourteen years by Dupont, Middeldorpf, Hutin, Azam, and other observers. Occasionally the result of a fracture, the most common cause of the abnormal communication is spontaneous, progressive absorption of the osseous tissue corresponding with the Pacchionian depressions, when, under the influence of slight traumatism, the blood escapes beneath the pericranium, where it forms a soft, fluctuating, reducible tumor, which augments during forced expiration, flexion of the head, and compression of the internal jugular veins, but diminishes during deep inspiration, and when the head is erect.

The venous tumor of the skull is very indolent, and rarely exceeds the volume of a Spanish chestnut. The treatment is entirely palliative, consisting in the protection of the part from accident by the application of a compress and suitable straps. In one instance, in which, through an error of diagnosis, an incision was made into it, the result was fatal.

4. *Aneurism by Anastomosis*.—The diploë is occasionally the seat of aneurism by anastomosis, arising either as a congenital defect, or as a consequence of injury. As the morbid growth advances, it causes absorption of the tables of the bones, and in this way a large tumor may ultimately be formed, pulsating synchronously with the heart's action, diminishing under pressure, and augmenting when the patient cries or makes any violent exertion.

Very little can be done for this disease, in the way of treatment, beyond keeping the patient quiet, and obviating all sources of mental excitement. In its earlier stages, trial may be made of gentle pressure or of subcutaneous ligation. The common carotid artery has been tied for it in a number of cases, but not, so far as I know, in a solitary one with any marked benefit.

5. *Pneumatocele*.—An emphysematous tumor of the scalp, technically called *pneumatocele*, is sometimes met with, and has been studied with great care by Costes, of Bordeaux, and Thomas, of Paris. Fracture of the skull, involving the frontal sinuses, the mastoid cells, or the petrous portion of the temporal bone, is its most common cause; but it may also be induced by necrosis, caries, and other diseased conditions, especially spontaneous, progressive atrophy of the osseous tissue, allowing the air to pass from the nose or the ear beneath the pericranium, where it forms a tumor, varying originally in size from a cherry to a pigeon's egg, painless, smooth, circumscribed, elastic, non-fluctuating, and resonant on percussion. During expiration, if the nose and mouth be closed, the air generally escapes with a hissing noise, and the swelling collapses or even completely disappears under pressure, but reappears the moment the pressure is removed. The tumor, which may eventually acquire a considerable bulk, is usually situated in the temporal, mastoid, or frontal region, the air lying immediately beneath the periosteum, which, however, may ultimately give way, thus permitting the fluid to diffuse itself more or less widely through the connective

tissue. It has been noticed in some of the reported instances that compression of the tumor was provocative of dizziness, lachrymation, cough, suffocative sensations, and suffusion of the countenance. Jarjavay, Balassa, and Chavance have each published the particulars of a case in which the tumor was dependent upon fracture of the petrous portion of the temporal bone, laying open the cavity of the tympanum.

The emphysematous tumor of the head augments slowly, several months often elapsing before it attains any considerable bulk, or manifests any tendency to diffuse itself over the skull, which, in rare cases, it may cover almost in its entire extent. When the diffusion is thus generalized, exploration with the fingers, while it diminishes the tumor, detects a remarkable alteration in the cranial bones, consisting in alternate, rounded, or acuminate elevations, with corresponding depressions, evidently due to a deposit of new osseous matter. The general health remains perfect.

The treatment consists in applying a firm bandage, or a closely-fitting cap of gutta-percha, the air, as a preliminary measure, having been pressed out with the fingers, if the tumor be reducible, or by a delicate trocar under opposite circumstances. Operative procedures, including incision, excision of the sac, or the insertion of a seton, with a view to the establishment of suppurative action, must be avoided, as they are liable to be followed by serious accidents, if not the death of the patient.

4. MALIGNANT TUMORS.

Carcinoma and Sarcoma.—Under the name of "*fungus*" of the dura mater, the older surgeons described a great variety of tumors, which modern research has reduced to two, carcinoma and sarcoma. Taking their rise usually on the inside of the skull, in the adherent portion of the dura mater, the morbid growth gradually extends until it perforates the cranium, and appears upon the exterior, spreading for a while underneath the scalp, and then ultimately pushing its way also through that structure. The most common site of the tumor is the base of the skull. The form of carcinoma usually met with in the dura mater is the encephaloid. Sarcoma generally presents itself as the spindle-celled variety; occasionally it contains giant cells, and Virchow has given an account of certain intracranial formations of this kind, consisting of a union of what he calls psammoma with gliosarcoma. Whatever their structure may be, the growth is usually solitary, of small size, seldom exceeding the volume of a pullet's egg or of a small orange. Although the origin of these tumors is usually referred to the dura mater, it is not improbable that they occasionally take their rise in the diploë, especially when they are developed under the influence of external injury. Cases have been witnessed in which, instead of making their way through the substance of the skull, they issued at the orbit of the eye, the ear, or the nares; in the latter event, perhaps, simulating a nasal polyp.

There are no signs by which such tumors can be distinguished in their earlier stages, or prior to their exit from the cranial cavity. The symptoms up to that time are solely of a functional character, evincive of cerebral disturbance. After the growth, whatever its structure may be, has perforated the skull, it will generally be found to be of an irregularly rounded, lobulated shape, hard at first, and afterwards soft and elastic, more or less painful, and the seat of pulsation synchronous with that of the heart. When ulceration has taken place, there is always more or less discharge of a very fetid, irritating matter, of a thin, ichorous character. The duration of life, in such a condition, is commonly very short, the patient being rapidly worn out by hectic irritation, death being often preceded by paralysis, coma, and convulsions.

In regard to treatment, palliation is almost the only thing to be thought of. There are, however, two cases upon record in which a permanent cure is said to have been effected by the operation of trephining and the total extirpation of the tumor, one of these having occurred in the hands of Grossmann and the other in those of Pecchioli. The probability is that in both instances the morbid growth was of a sarcomatous character, and not carcinomatous.

A sarcomatous tumor of the skull, evidently beginning in the pericranium, is also sometimes met with. A remarkable case of the recurring fibrous variety of this growth, extending over a period of twenty-four years, in a man, aged forty-four, has been reported by Billroth. It originally appeared on the back of the head as a firm, painless nodule, which was extirpated when it had attained the volume of a walnut. Returning at the cicatrice ten years subsequently, it was allowed to go on for five

years, when it also was excised; but new growths soon appeared at the same site, and in three years, when they were removed, they had attained the diameter of a German two-dollar piece. The denuded skull was cauterized with the hot iron, the application being followed by a superficial exfoliation. Two years after the third operation, the entire occipital region was found to be studded with hard tubercles, varying in size from a bean to that of a cherry, and reaching down over the back of the neck. The whole mass, including enlarged glands and vessels, was now dissected away from the bones and muscles, and in three months the huge wound was perfectly cicatrized. In the meantime, however, new growths sprung up among the cervical muscles and in the new inodular tissue; and, although the actual cautery was freely used, the man, after nearly two years more of cruel suffering, finally succumbed in a state of complete exhaustion.

5. MALFORMATIONS.

a. Meningocele.—Meningocele is a congenital tumor of the head, most common in the occipital region, but sometimes also met with in the parietal and frontal. It is usually situated at the middle line, and, as the name implies, is filled with cephalospinal fluid, protruding along with the membranes of the brain through a small opening in the skull, a fontanel, or a suture. The tumor, originally, perhaps, not larger than a pea or cherry, is capable of acquiring a considerable bulk, and is generally of an elongated, conical form, with a rather narrow neck. It is free from pain and pulsation, of a smooth, shining appearance, fluctuates more or less distinctly, is in great degree divested of hair, and is rendered tense in crying, sneezing, coughing, or forced expiration. When small, it may be almost completely effaced by pressure. It is essentially composed of the scalp and of the envelops of the brain. Its contents are perfectly limpid and uncoagulable.

Meningocele must not be confounded with hydrocephalus and encephalocele. The chief points of distinction are, its small size, its conical form, its softness, its translucency, and its partial subsidence under pressure.

The prognosis is generally unfavorable. A cure may sometimes be effected when the cranial opening is very small; but under opposite conditions relief is commonly impracticable.

The treatment must be by compression or ligation. The former may be conducted by means of a piece of sheet lead, confined by a bandage, the tumor having previously been reduced by puncture with a delicate needle. It should be steadily maintained for several months, and be aided by the occasional application of iodine.

Ligation is a dangerous operation, and yet it may be the only resource. The ligature should be firmly applied to the base of the tumor, so as to cause immediate strangulation. In a case of this description, under my charge, in a child, fourteen months old, subjected to this treatment at the College Clinic in 1863, death occurred at the end of the sixth day, from arachnitis. The tumor, which was of a conical shape, grew from the centre of the occiput, and was at birth about the volume of a small hazelnut. It remained nearly stationary until the tenth month, when it rapidly increased in size, and at the time of the operation it was an inch in length by half an inch in diameter.

β. Encephalocele.—Encephalocele, or hernia of the brain, is a rare congenital malformation, generally associated with meningocele, and always connected with, if not directly dependent upon, a defective state of the cranium. Its most common site is the occipital region, 53 of 79 cases analyzed by Mr. Z. Laurence being in this situation. Occasionally it is met with at the root of the nose, at the frontal suture, immediately over the eye, or at the base of the skull. In the latter event it sometimes projects into the nose or even into the mouth. Of 39 of the above cases in which the sex is mentioned, 21 were males, and 18 were females. The size of the tumor varies from a small nut to that of a foetal head, according to its age and other circumstances. The contents consist either of a portion of the cerebellum, as in fig. 76, from Bryant, or of the cerebrum, protruded through a



Fig. 76.

Encephalocele.

circular, oval, or triangular opening in the skull, the edges of which are nearly always rounded off, and somewhat thinner than the adjacent bone. The coverings consist of the scalp, epicranial aponeurosis, dura mater, and arachnoid membrane. The form of the tumor is either spherical, oval, or cylindrical. The affection is frequently associated with other malformations, as bifid spine, harelip, cleft palate, or club-foot. When it occurs along with meningocele, it constitutes what is called hydrocephalocele.

The history of the case and a careful examination of the scalp are the safest guides to the diagnosis of the affection. The diseases with which it is most liable to be confounded are meningocele, and various morbid formations, as serous, bloody, and other tumors. When the protrusion is solid, it feels hard and faintly elastic, whereas when it is partly fluid and partly solid, it will be soft and fluctuating, or soft at the top and hard at the base. It diminishes under pressure, and increases under mental emotion. In rare cases pulsation, synchronous with that of the heart, is perceptible. The intellect is usually unimpaired, but pressure causes momentary coma, partial paralysis, and other symptoms of cerebral disturbance.

Most of the subjects of encephalocele are either stillborn, or they die soon after birth. In the cases collected by Laurence only six reached adult age. Adams met with an instance at twenty and Guyenot at thirty-three years.

The principal remedies are ligation, excision, and compression, conjoined with puncture when the affection is associated with meningocele. These means, however, afford but little prospect of relief, and experience is decidedly in favor of non-interference. In only one instance, so far as I know, was the protruding portion of brain sliced off successfully, the patient making a good recovery.

γ. *Hydrocephalus*.—Hydrocephalus, or dropsy of the brain, is fortunately a rare occurrence, for it is nearly always fatal, whatever treatment may be adopted for its relief. In regard to its pathology, there has been much diversity of opinion; my own belief, founded upon a careful observation of a considerable number of cases, is that the disease essentially consists in subacute or chronic arachnitis, commencing generally some time before birth, and going on gradually increasing until the head attains an enormous volume, causing hideous deformity. It would, perhaps, be wrong altogether to deny that the affection may occasionally commence after birth, but, if such an event does happen, it must be very uncommon; for, even when a child thus affected is apparently healthy when ushered into the world, well-marked signs of the disease usually arise so soon afterwards as to lead to the conviction that its origin was laid during intra-uterine life; probably in some inscrutable vice of the constitution.

The fluid, consisting almost wholly of water, with some of the earthly salts and a little sugar, but hardly any albumen, usually occupies the ventricles of the brain, which, as the accumulation augments, is at length completely unfolded, forming a layer, perhaps, not more than from three to six lines in thickness, in which it is difficult, if not impossible, to distinguish any white and gray substance. In some instances, it is situated in the arachnoid sac, on the surface of the brain, which, in consequence of the severe and long-continued pressure of the water, is generally very much atrophied and distorted. I have not met with any examples in which the fluid was lodged between the cranium and the dura mater, and doubt whether it ever occurs here, as this membrane does not possess the power of secreting serum.

The quantity of water varies from a few ounces to several quarts. Cases have been reported in which upwards of fifty ounces were drawn off at one operation during life, and more than twice that amount has occasionally been found on dissection.

The disease is always chronic, and often continues for years before it proves fatal. The health, however, usually suffers at an early period; the child becomes thin and emaciated, loses control over its muscles, and requires to be fed, although the appetite may be quite voracious. Convulsive twitchings are of common occurrence, the eyes roll constantly about in their sockets, the pupils are dilated, speech is absent, and the urine and feces commonly flow off involuntarily. The head, in the more advanced stages of the disease, is sadly misshapen, and altogether too heavy for the weakened body. The fontanels are wide open, the cranial bones are abnormally thin and expanded, almost like parchment, and the subcutaneous veins of the scalp are enormously enlarged. The mind is generally idiotic, and existence purely vegetative, the brain being sometimes almost completely absorbed,

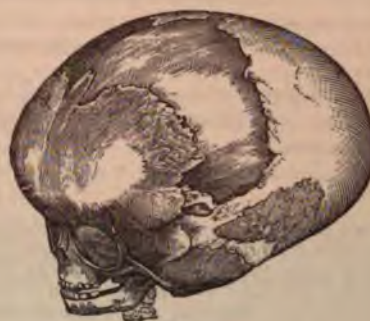
as in the interesting cases related by Delafield, Glover, Blackman, and others. The peculiar appearances of the head in hydrocephalus are well seen in fig. 77, from one of my clinical cases. Fig. 78 exhibits the state of the bones and fontanel, divested of their soft parts.

Fig. 77.



Chronic Hydrocephalus.

Fig. 78.



Skull of a Hydrocephalic Child.

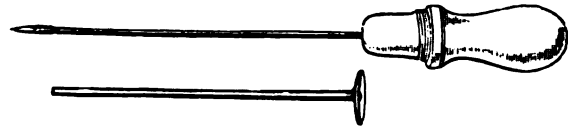
A spontaneous cure of this disease occasionally occurs. Nélaton mentions a case where the cure was apparently due to a cutaneous eruption attended with diarrhœa and copious perspiration; and a somewhat similar instance has been recorded by Dr. J. W. Hubbell. Frank attended a child who recovered after an attack of scrofula. The period at which death occurs when the disease is permitted to pursue its course is extremely variable. Dr. West refers to a case in which the patient lived to the age of twenty-nine years, and Baillie met with one which attained the age of fifty-six.

In such a disease as this, little, if anything, is to be expected from treatment. In the milder cases, especially in their earlier stages, benefit sometimes accrues from the steady use of sorbefacient applications to the head, as iodized unguents or lotions, and the exhibition of iodide of potassium and bichloride of mercury, aided by an occasional laxative, and a properly regulated diet. Shaving the scalp, and afterwards vesicating it with cantharides, have sometimes proved useful. No advantage could reasonably be expected from counter-irritation by a seton or by an issue in the nape of the neck. Regular, systematic compression has repeatedly been tried, either with adhesive strips, or the roller, or both together, and a few cases have been reported of its supposed efficacy. Usually, however, the cure is only temporary, and it is proper to add that the treatment is often followed by convulsions, thus necessitating its abandonment.

What is true of medication is equally applicable to paracentesis, concerning which some most marvellous statements have been published. Thus, Conquest asserts that by this operation he cured not less than 10 cases out of 19. Of 63 cases collected by Dr. West, of London, 18 are said to have been restored. I doubt, however, very much whether radical relief has ever followed such a procedure. In the only two instances in which I have performed the operation, death in each ensued in less than four days from convulsions; and such must, I feel confident, generally be the result when the accumulation is at all considerable, no matter how carefully the treatment may be conducted after the evacuation of the fluid, the maintenance of life being inconsistent with the sudden removal of such an amount of pressure as attends confirmed dropsy of the brain. The operation, originally performed by Le Cat, in 1744, and repeated by Remmet, of England, in 1778, consists in perforating the anterior fontanel with a very delicate trocar, fig. 79, introduced some distance from the longitudinal sinus, the opening being closed, as soon as about two-thirds of the fluid has been withdrawn, with collodion

and adhesive plaster, applied in such a manner as to make firm and equable pressure upon the collapsed cranium, and to prevent the entrance of air. The operation

Fig. 79.



Trepan for Puncture of the Cranium.

may be repeated once a week. The child should be kept well under the influence of chloral and bromide of potassium during the after-treatment, to control nervous irritation.

SECT. III.—CEREBRAL AFFECTIONS.

Under this caption may be described certain lesions of the brain, the result of blows and other external injury, accompanied or not accompanied, as the case may be, by fracture of the skull, as concussion, contusion, compression, irritation, inflammation and abscess, or extravasation of pus and other fluids. Fractures of the skull and wounds of the brain will be treated of under separate heads.

1. CONCUSSION OF THE BRAIN.

Concussion of the brain has been variously defined by different writers, hardly any two agreeing in regard to it. The most common idea appears to be that it is a commotion of the nervous fibres, or, more properly speaking, of the nervous tubes, inducing a change, vague and indefinable, in the relations which they sustain to each other and to their vessels. How far such a view is worthy of adoption it is not easy to determine; for it is very certain that, notwithstanding all that has been said upon the subject from the earliest periods of medicine down to the present, the progress of science has failed to afford us any substantial light respecting the true mechanism of this occurrence. The modern pathologist, in surveying this interesting and important topic, finds that he has no reason to pride himself upon his knowledge; if he attempts to penetrate beyond the trodden paths of his predecessors, doubts and difficulties meet him at every turn, and soon compel him to retrace his steps.

If we reflect upon the pulpy structure of the brain, it is surprising that any one should ever have seriously entertained the idea that, during concussion, this organ experiences a diminution of size, from the condensation of its constituents. Such an explanation is certainly not well calculated to afford us any very correct conceptions of the nature of this lesion. Accurately filling the cranial cavity, it is impossible that the brain could undergo any change of bulk from a mere commotion of its substance. A decrease of size can be effected only by the action of the absorbents, not suddenly, but gradually, in a manner altogether irreconcilable with the production of concussion. The theory of an increase of bulk of the organ is equally absurd, inasmuch as such an occurrence can only take place in consequence either of extravasation of blood or of inflammatory exudation. The only idea that I can form of the nature of the injury is that it is caused by the jarring of the nervous substance, eventuating, at least in severe cases, in a loss of its consistence, if not in its positive laceration. To show how plausible this view is, it is only necessary to inquire into the character of the exciting causes of concussion. In general, the accident is produced by direct violence, as a blow or fall upon the head. Now, when this happens, it is easy to perceive how the brain is influenced by the vibratory movements communicated to it by the osseous case which incloses it. The force of the injury, instead of being expended upon the skull, is transmitted to the cerebral substance, which it jars very much as a bow may be supposed to be jarred in discharging an arrow. When the blow is slight, the effect will be proportionately mild, the patient being, perhaps, merely stunned; but when the force is severe or concentrated, the result will be different, the substance of the brain being not only shaken, but, it may be, severely contused and even lacerated, the lesion exhibiting itself in

the form of a fissure, which is immediately filled with blood, from the rupture of the small vessels.

Similar effects occur when the concussion is occasioned by violence applied indirectly, as when a person falling from a considerable height, alights upon his feet, knees, or buttocks. Here the force of the injury is transmitted along the bones of the extremities, and thence along the spine to the base of the skull, where, exploding, it is communicated to the brain, very much in the same manner as when the head is struck with a hard body, as a bludgeon, poker, or brick. The effect of this form of concussion may be illustrated by what occurs in the boyish amusement of killing woodpeckers in countries abounding in cherries. To prevent the depredations of these marauders, a slender pole is sunk into the earth, the free end protruding at the top of the tree. When the bird alights, the pole is struck with an axe, and the vibratory motion thus transmitted through the fibres of the wood to his body instantly kills him. Now, in this case, death is caused, not by any change of bulk in the brain, nor by any alteration in its consistence, but simply by the jarring of its substance, disqualifying it for the transmission of the vital fluid, and, consequently, also for the maintenance of its circulation.

Dissection has thrown little, if any, positive light upon the nature of concussion. All that the knife has revealed in those who have perished from the immediate effects of the accident is of a negative character. The most minute inspection, both with and without glasses, has failed, in ordinary cases, to detect the slightest lesion of the cerebral tissues. Even in the worst forms, as those associated with compression, the most that has been found has been a laceration, commonly sufficiently insignificant, of some portion of the organ, attended, perhaps, with a trifling extravasation of blood. Sometimes, as when the rent has been more extensive, involving, it may be, the surface of the hemispheres, or the lateral ventricles, the effusion has been more considerable, but such an event constitutes the exception, not the rule.

As concussion of the brain may exist in various degrees, so the *symptoms* which characterize it may present various shades of difference, depending upon the severity of the injury; hence it will be proper to study these symptoms with reference to their diagnostic and therapeutic value. It will greatly facilitate the comprehension of the subject if we adopt the division of concussion into the three stages of collapse, reaction, and inflammation, usually recognized by writers and teachers; for, although such an arrangement is altogether arbitrary, and, therefore, unnatural, yet something of the kind is absolutely necessary for the sake of clearness of description.

1. The stage of *collapse* is characterized by symptoms of exhaustion, not unlike those produced by the loss of blood. The system has received a shock, varying from the slightest functional disturbance to complete insensibility, life being suspended, as it were, merely by a feeble thread. In the former case there will probably be only slight pallor of the countenance, a confusion of ideas, a disposition to yawn, and a feeling of nausea. The patient rubs his eyes, stares wildly around, and perhaps vomits; but, presently recovering his consciousness, he gets up, and goes about his business as if little or nothing had occurred. This is an example of slight concussion, such as happens when a man is pitched gently off a horse, thrown out of his carriage, or struck upon the head. When the lesion exists in a more aggravated degree, these symptoms will not only be much more distinctly marked, but of longer duration, a number of hours, perhaps, elapsing before reaction sets in. The prostration is profound; the countenance is of a deadly pallor; the breathing is almost extinct; the pulse is soft, feeble, fluttering, and intermittent, sometimes hardly perceptible; the loss of strength is complete; deglutition is impossible; the stomach, oppressed with nausea, perhaps lazily ejects its contents; the bowels are relaxed, and there are occasionally involuntary discharges; the pupils are usually contracted, but still somewhat sensible to light, or one is diminished and the other dilated, or, finally, one is contracted and the other natural; special sensation is in a state of abeyance; the mind is prostrated; and the patient, roused with difficulty, answers, if spoken to, in a drawing monosyllable. The surface of the body soon becomes cold, and is often bathed with perspiration. The condition of the bladder varies; generally the urine passes off in the natural way or with more or less dribbling, but sometimes it is retained and requires to be drawn off with the catheter.

The duration of this stage varies from a few minutes to several hours or even days, depending upon the extent and severity of the lesion. When the functional disturb-

ance is slight, it may last only a very short time, otherwise the prostration will be more persistent, and sinking may occur, without any effort at reaction.

Concussion of the brain is sometimes followed by bleeding of the ears without there being necessarily any fracture of the base of the skull, simply as the result of a laceration of the vessels of the soft parts. Of twenty-two cases of concussion recorded by Laurie and King, of Glasgow, twenty recovered, and in only one of the two that died was there any fracture at the base of the cranium. Nasal hemorrhage is by no means uncommon in injuries of this kind, especially when the concussion has been caused by a blow or fall upon the forehead.

The leading indication in the stage of collapse is to establish reaction, or to rouse the enfeebled, and, perhaps, flagging energies of life. This object may usually be attained by very simple means, promptly and judiciously employed. The first thing to be done is to place the patient recumbent, with his head on a level with the body, or, if the symptoms are at all urgent, even considerably lower, in order that the heart, exhausted by the shock, may be enabled to throw the blood with more facility to the exhausted brain. Free access of air is next procured, by opening the doors and windows of the apartment, and by the active use of the fan. Any bystanders, or idle spectators, must immediately be sent away, as their presence cannot fail to be prejudicial to the patient. Any tight garments, especially the collar and pantaloons, must promptly be relaxed, to give full play to the respiratory muscles. Cold water is freely dashed upon the face and chest, smelling bottles are held near the nose, not steadily, but intermittently, and sinapisms are applied to the extremities and to the precordial region. In the milder forms of concussion, these means are generally amply sufficient for the speedy establishment of reaction; but when the case is very severe, it may be necessary, in addition, to place sinapisms along the whole length of the spine, and to employ stimulating injections, as water impregnated with mustard, common salt, alcohol, ether, or spirit of ammonia. If the feet are cold, they may be immersed in warm water, or rubbed with hot cloths, and afterwards wrapped up in warm flannel and surrounded with hot bottles. As soon as the patient is able to swallow, he may take a little cold water, or water and brandy, the latter being more especially indicated when the system is long in showing signs of reaction. Spontaneous vomiting sometimes greatly promotes restoration, particularly if a hearty meal was taken shortly before the occurrence of the accident; a heavy load being thus removed, the diaphragm enjoys greater play, the pneumogastric nerves act with increased vigor, and the heart propels the blood with greater force to the paralyzed brain.

As life returns, color succeeds pallor, warmth coldness, and intelligence confusion of ideas; the pulse resumes its wonted force and activity, the respiration becomes more natural, the stomach is relieved of nausea, the sphincters recover their proper functions, the special senses are again on the alert, and volition is exercised with its proper freedom. The restoration may be rapid or gradual, temporary or permanent; once fully established, however, it rarely recedes, but, on the contrary, steadily advances, with a tendency, not unfrequently, to over-action.

In treating concussion of the brain, the young practitioner is apt to be led into several serious errors, especially if he is surrounded by officious bystanders, and not perfectly self-possessed.

1st. He may be foolish enough to draw blood, or, at all events, to attempt to draw blood, while his patient is in a state of profound exhaustion, unable, perhaps, to crook a finger or utter a syllable. Nothing is more common immediately after such accidents than for the friends of the patient to insist vociferously upon his being bled; and if the practitioner, in an unguarded moment, yields to the silly request, he may destroy life on the instant, or render reaction very difficult, if not impossible. To bleed a man in such a condition is as absurd and culpable as to bleed him when he is in a state of syncope from the loss of blood.

2d. Great care should be taken in the use of ammonia, and other pungent articles, not to hold them too near the nose, lest they induce spasm of the glottis, and thus suffocate the patient. Moreover, their employment may give rise to inflammation of the nares, fauces, larynx, and trachea.

3d. The practice of pouring drinks into the patient's mouth, before he is able to swallow, cannot be too pointedly condemned. It is fraught with great danger, on account of the liability of the fluid to pass into the windpipe, where even a small quantity might induce suffocation. The patient should, therefore, be sufficiently

conscious to know what is being done to him, or, if he cannot be properly roused, and the symptoms are very urgent, the fluid should be placed in contact with the fauces, beyond the reach of the larynx, the act of deglutition being thus excited without any risk of injury.

4th. When stimulants are used, due regard must be had to their quality and quantity, as well as to the period of their administration. Brandy, as a general rule, is preferable to anything else, but it should be given sparingly, and its use be suspended the moment reaction has fairly commenced. The object is to rouse the system gradually, not rapidly, to coax, not to force, the jaded powers of life; this wish attained, all artificial excitants are refrained from. In ordinary cases no internal stimulants are required.

5th. The accident may have occurred soon after a hearty meal, and then the question may arise in regard to the propriety of exhibiting an emetic. Nature sometimes decides this for the practitioner, by the institution of spontaneous vomiting; but when this does not happen, and there is no contraindication, as there will be when the concussion is complicated with compression, it may be excited by salt and mustard, ipecacuanha, alum, or zinc, followed by large draughts of tepid water. During the act of emesis, whether occurring spontaneously or induced artificially, the patient should lie with his head inclined forwards, otherwise some of the ingesta, as they are lazily ejected, may drop into the air-passages, and so cause fatal asphyxia.

2. *Reaction* being established, the surgeon's duty plainly is not to fold his arms idly, on the one hand, nor to be over-officious, on the other. His business is to stand as a guard over his patient, carefully watching, and measuring, as it were, every symptom as it arises, in order, if possible, to form a just appreciation of its pathological import, and to seize the earliest moment to counteract any aberration from the healthy action. The great danger now is from inflammation of the brain. Usually, after the patient has completely regained his faculties, it is observed that the functions which were suspended are performed with a slight degree of excitement; but this is not to be taken as an evidence for active interference; on the contrary, it generally disappears spontaneously in a few hours, the surface becoming moist, and the pulse losing its sharpness and frequency. The diet is light and non-stimulant, perfect quietude of mind and body is enjoined, and the bowels are moved by gentle laxatives. If the shock has been at all severe, the patient is warned against premature exposure, even if the symptoms have happily passed off; he must consider himself as an invalid for weeks, and avoid everything that may awaken excitement in the recently shattered organ, now peculiarly prone to take on morbid action from the slightest causes. The head must be sedulously watched, and any pain of which it may be the seat must be looked upon with suspicion, especially if it be combined with irritability of temper, vitiated appetite, and a sharp, frequent pulse. A brisk purgative, and a few leeches to the temple, or the abstraction of a little blood from the arm, may avert the threatened evil, and prevent it from passing the natural limits, while the delay, even of a day, may enable it to reach a crisis which may speedily prove destructive to life.

3. *Over-action* of the system, consequent upon the cerebral lesion, constitutes the third stage of concussion. The period of its access is variable. Generally it comes on within the first four or five days, sometimes, indeed, within the first four-and-twenty hours; on the other hand, instances not unfrequently occur in which it does not manifest itself for weeks and even months, the patient considering himself all the while out of danger, and fully competent to attend to his daily occupation. In the former case, the disease is usually bold and undisguised; in the latter, it is often latent, its approaches being slow and stealthy, and its progress, consequently, often considerable before its true nature is discovered. Such examples are always peculiarly dangerous, on account of their liability to be overlooked and mismanaged.

2. CONTUSION OF THE BRAIN.

Contusion of the brain, first recognized as a distinct lesion by Desault, and afterwards more accurately described by Dupuytren, may be defined to be a sudden and violent attrition of a portion of its substance, attended with more or less laceration, and an effusion of blood, generally in the form of minute specks or little clots. It may present itself in two distinct varieties of form, the circumscribed and the dif-

fused, the latter, which sometimes involves a large extent of tissue, being by far the less common. Resulting from the same causes as concussion of the brain, with which it is, in fact, almost constantly associated, the more serious cases are commonly the consequence of concentrated force, or of force applied with a pointed weapon. To produce it, however, there need not necessarily be a fracture of the skull, nor, indeed, any injury whatever of the calvaria; a fall upon the feet, knees, or nates is, at times, quite sufficient to give rise to it. Occasionally it follows apparently very slight blows upon the head. However this may be, the bruise is ordinarily direct, that is, at the part struck, although it may also be indirect, or at a considerable distance off, especially when it is caused by *contre-coup*. In the latter case, indeed, it is often immediately opposite the seat of the blow.

The most common situation of the lesion is the cerebrum, in its under part, owing, doubtless, to the intimate relation of this portion of the organ with the sharp edges of bone at the base of the skull. The cerebellum, pons, crura, and medulla are comparatively seldom affected.

The extent of the injury varies from a few small patches, so slight, perhaps, as to be hardly distinguishable, to a greater portion of an entire lobe, or even a large portion of one of the hemispheres. The most severe cases are usually connected with fracture of the cranium, with or without depression. Marked evidences of it almost invariably exist in fracture of the base of the skull, caused by blows or falls upon the vertex. Occasionally the lesion occurs at several points, more or less remote from each other, as the cerebrum, cerebellum, pons, and fornix, or the cerebrum, fornix, and medulla.

The contusion varies also in degree. In the circumscribed variety, the patches, in the milder cases, are confined exclusively to the gray substance, and are frequently not more than a few lines in diameter; they are of a dark-purplish hue, and are interspersed with minute specks of blood, not larger than pin-points, and more or less closely grouped, a section strongly resembling the appearances produced in capillary apoplexy. When the injury has been unusually violent, the discoloration is much deeper, as well as more uniform, and the affected part, torn, softened, and disorganized, is thoroughly infiltrated with blood, small clots of which, generally not exceeding the volume of a pea, are at the same time imbedded in its substance. Both the gray and white tissues are implicated, often to a great extent and in a high degree. The slight and severe forms frequently coexist in the same brain.

In the diffused variety of the lesion the extravasations are more or less widely disseminated; their size varies from that of the smallest pin-point to that of a millet-seed or a split pea, and they often exist in considerable numbers, although cases occur in which there are so few that, unless a very careful dissection be made, they may altogether elude detection. The cerebral substance around these clots is generally somewhat softened, and occasionally also a good deal discolored.

If death occur soon after such an accident, the extravasated blood, whether appearing as pin-point specks or small clots, is usually found to be quite soft and of a dark color; after the lapse, however, of a few days, it is generally solid, and often a few shades lighter. At a still later period, it is partially, if not completely, absorbed, and replaced by a minute yellowish spot, containing, not unfrequently, a little serous fluid, precisely as in ordinary apoplexy.

The membranes of the brain are variously affected. In the slighter forms of the injury there may simply be an infiltrated, ecchymosed condition of the pia mater in the vicinity of the lesion, but in the more severe cases there is nearly always, in addition to this, more or less laceration of this membrane and of the arachnoid, with extravasation of blood into the sac of the latter, and occasionally also extensive detachment of the dura mater. Mr. Prescott Hewett, who has studied this subject with great care and attention, states that out of 69 cases of more or less severe contusion of the brain, independently of compound fracture, he found blood poured out in this situation in not less than 52, the quantity in 31 being so large as to cap the brain.

The *symptoms* of this affection are, in general, so vague and ill-defined that it is not surprising that its true nature should often be overlooked. Its recognition is the more difficult because it is nearly always accompanied with concussion, the symptoms of which, running into those of contusion, thus occasion an inextricable blending of the characteristics of the two lesions. Then, again, it is to be recollected that there must necessarily be many cases in which the affection is associated with,

and masked by, compression of the brain, the result either of more or less copious extravasation of blood or of fracture of the skull with depression of bone. Hence, if an attempt be made to separate the more simple cases of contusion from the complicated, the number will be found to be exceedingly limited.

Dupuytren, who, as already stated, was the first to call special attention to this lesion, came to the conclusion, in formulating the results of his experience, that the earliest reliable phenomena did not appear until about the fifth day, or the usual period for the supervention of cerebral inflammation. Observations, however, made since his time, have led to a different result. In general, it may be inferred, especially in the absence of fracture, that the lesion is one of contusion, when, the first symptoms of shock having passed away, the disturbance of the brain more or less obstinately persists. This conclusion will be rendered so much the more probable when there is pretty complete loss of consciousness, along with an uncommon degree of somnolency, but no stertorous respiration; when there is extreme agitation and restlessness, the patient tossing continually about in bed; when there is rigid contraction of one or more of the limbs, especially of the fingers; and, finally, when there is more or less delirium during the first few days after the accident, with a gradual but steady aggravation of all the symptoms. In the milder cases of contusion there may merely be some contraction of one of the pupils, partial paralysis of an eyelid, impaired vision, indistinctness of articulation, slight spasmodic twitching of the muscles of the face, partial loss of memory, pain in the head, especially at the seat of the part struck, and defective sensation, or want of control over the action of the sphincters. When the lesion is complicated with fracture of the cranium, whether with or without depression, all effort at discrimination must be abortive. Finally, it must not be forgotten that, in the milder forms of contusion, the symptoms must necessarily be proportionately insignificant and evanescent, cerebral accommodation occurring within a short time after the accident.

There is occasionally what may be called a mixed form of contusion and compression of the brain, as in a case recently under my observation in a very stout, heavy, muscular man, upwards of fifty years of age, who, in a rapid drive, was thrown out of his carriage upon the top of his head. He was picked up in a state of insensibility, in which he remained until he expired three days after. His breathing became stertorous some hours after the accident, and his right side paralyzed. There was no wound or abrasion of the scalp, nor any fracture of the skull. The vessels of the pia mater were very much engorged, and innumerable little specks of blood, hardly the size of a common pin-head, were scattered through the hemispheres of the brain. The anterior lobes of the cerebrum contained each several clots of blood of the volume of an ordinary bean. Coagulated blood was also contained in the lateral ventricles, particularly in the left. The cerebellum and medulla oblongata were sound.

The *prognosis* varies with the extent of the lesion, the presence or absence of complications, and the condition of the patient at the time of the accident. The milder cases will generally recover with little or no treatment, the effused blood being more or less rapidly absorbed, and the lacerated tissues gradually repaired. When, on the contrary, the contusion is very severe, the worst consequences are to be apprehended, death happening either soon after the infliction of the injury from structural disorganization, or secondarily from the effects of inflammation of the brain and its envelops.

The *treatment* must be regulated according to the general principles of practice applicable to other injuries of the brain and its membranes. The earlier symptoms are usually those of concussion or shock, and should, therefore, be combated by such means as are adapted to favor gradual reaction, as recumbency, access of cold air, the use of the smelling bottle, and the administration of ammonia, or, in the more severe cases, of some stronger stimulants. When this object has been accomplished, the chief duty of the attendant is to watch the patient that he may not, by overfeeding, neglect of his bowels, or premature exertion and exposure, bring on inflammation, the great source of danger after such an occurrence. The period when this may be looked for is, on an average, from the fourth to the sixth day; up to this period, therefore, as well as for some time after, his vigilance should rather increase than relax; every avenue should be guarded with the greatest care, and the slightest approaches of the enemy met with the most vigorous measures. The hard,

frequent, quick, and jerking pulse, the intolerance of light and noise, the excessive restlessness and thirst, the suffused eye and flushed cheek, and the wandering intellect, with a tendency to coma, paralysis, and convulsions, are signs of evil import, which it is generally much easier to prevent than to control successfully after they have made their appearance. If the patient is plethoric, he must be freely bled at the arm or by leeches at the temples and behind the ears; the bowels moved by active cathartics; the head shaved, elevated, and cooled with pounded ice; in short, no effort must be spared to crush out the disease in its incipency. The more remote effects of the lesion are combated by tonics and alterants, proper regulation of the diet and bowels, and change of air.

3. COMPRESSION OF THE BRAIN.

It is hardly possible to give a more satisfactory definition of compression of the brain than of concussion. Every surgeon knows what import to attach to the expression, but to say what compression is, or how it is produced, are questions that have puzzled and perplexed many of the wisest men in the profession. The legitimate meaning of the term, and as it is generally understood, is that the cerebral substance is pressed, by some eccentric force, into an unnatural space, or, in other words, that the normal volume of the part pressed upon is diminished. But is this really the case? Is it possible to compress an organ composed of so pulpy a structure as the brain? I cannot myself conceive of such an occurrence, unless we take a portion of brain and subject it to an amount of artificial pressure such as is altogether inconsistent with what takes place even in the worst cases of compression within the skull. We can conceive how the different portions of the brain may be changed in their relations; how one part may be flattened and another part expanded in consequence; how, for instance, the convolutions of the hemispheres may be pressed out, and how their furrows may be effaced; how the lateral ventricles may be encroached upon, and even obliterated; how the vessels of the brain may be flattened and destroyed; but we cannot conceive how the cerebral tissues can be so condensed and squeezed together as to occupy less space than in the natural state. This view of the case, it seems to me, is the only one that is at all admissible, and, therefore, if it be assumed to be correct, it follows that compression of the brain is merely a change of the relative position of the component portions of the organ, and not what the term really signifies in its etymological sense. Dissection affords daily proof of the correctness of this opinion. The greater part of a whole hemisphere is sometimes flattened by an enormous coagulum, and yet, if the affected portion could be accurately measured, it would be found to occupy as much space as in the normal state, or as it did previously to the accident. The change is observed to depend mainly, if not exclusively, upon the depression of the convolutions and the effacement of the intervening spaces, and not upon any condensation of the cerebral tissues, or any actual reduction of their volume. The pressure exerted by the clot could not act in any other manner, because its force is not sufficient; nor is it possible for a piece of bone to cause any more efficient pressure, for the moment the force thus applied exceeds the force of the resistance, the brain gives way, and projects up beyond the edges of the depressed bone.

Compression of the brain may arise from various causes, but, surgically considered, they may all be referred to four classes, extravasated blood, depressed bone, effused pus, and foreign bodies.

However induced, the *symptoms* of compression are always of the same character, and are generally easily recognized, as every organ of the body is affected by the cerebral disorder. The period of their appearance is influenced by the nature of the exciting cause. When the compression is dependent upon depression of bone, the symptoms are usually immediate, whereas in compression from extravasation of blood some little time often elapses, especially when there is great shock. In compression from effusion of matter, a number of days intervene between the occurrence of the injury and the appearance of the symptoms, the parts being obliged to pass through the several stages of inflammation before they can reach the suppurative crisis.

A person laboring under compression of the brain is deprived of sensibility and motion; he is unconscious of what is passing around him; if spoken to, he makes no reply, not even in a monosyllable; he cannot hear, nor see, nor taste, nor smell, nor has he any power to articulate, to swallow, or to protrude his tongue. The

countenance is ghastly pale and devoid of expression; the eyes are turned up, glassy, and fixed; the lids are closed; the pupils are widely dilated, and insensible to light; the breathing is slow, labored, stertorous, and performed with a peculiar whiffing or blowing sound; there is hemiplegia, or paralysis of the side opposite to the seat of injury, and, as a necessary consequence, the corner of the mouth is drawn over towards the sound side; the pulse is slow and oppressed; the stomach and bowels are torpid; and the bladder is incapable of expelling its contents.

These symptoms do not always exist in the same degree, nor are they all equally well marked in every case. The compressing cause being slight, the phenomena will be proportionately mild. Thus, the patient may only be partially insensible; his intelligence may be weakened, but not abolished; the special senses may still be able to perform their functions, although very imperfectly; the paralysis may be confined to one limb, or to certain muscles; the pupils, pulse, and respiration may only be slightly altered; the bowels may be torpid, but only in a moderate degree; and the bladder may still be able to expel a portion of its contents. If the foot is pinched, the patient will moan, or draw the limb away, thus showing that he has still some feeling, if not motor power.

The paralysis which attends this affection is usually on the side opposite to that of the compressing agent, the occurrence being generally supposed to depend upon the decussation of the fibres at the base of the brain. This is doubtless true, but whether it be or not, the fact is of great practical importance in relation to any operations that may be required for the patient's relief. In a few instances, as inexplicable as they are rare, the paralysis exists on the same side as the cause of compression.

The state of the pupils is very variable. In general, they are widely dilated, but occasionally they are contracted, and cases occur in which one is contracted and the other dilated. A diminution of both pupils is extremely uncommon.

The stertor in this affection is caused by paralysis of the palate, which, hanging like a loose curtain in the throat, flaps to and fro as the air passes in and out of the lungs during respiration. The blowing, whiffing sound, and the distension of the cheeks, are due to the loss of tone in the buccinator and labial muscles.

Differential Diagnosis.—If the cerebral affections above described were always clearly defined, or, what is the same thing, if they were always uncomplicated, it would be difficult, if not impossible, to confound them either with each other or with other diseases; but such, unfortunately, is not the case. Not unfrequently they are so blended together as to render it impossible to determine what the true nature of the lesion is, and what share is due, respectively, to concussion, contusion, or compression. As such an occurrence is always extremely embarrassing, and must, to a greater or less extent, influence the nature of the treatment, it is the duty of the surgeon to study the features of each complaint, in its more simple forms, so that, when he meets with them in association, he may be the better able to discern their various shades of difference. The more important phenomena of concussion and compression are here subjoined in tabular form, those of contusion not admitting of such an arrangement.

CONCUSSION.

1. The symptoms are immediate, coming on instantly after the infliction of the injury.
2. The patient is able to answer questions, although with difficulty, and usually only in monosyllables, as yes or no.
3. Special sensation is still going on, the patient being able to hear, see, smell, taste, and feel.
4. The respiration is feeble, imperfect, and noiseless.
5. The pulse is weak, tremulous, intermittent, and unnaturally frequent.
6. There is nausea, and sometimes vomiting.
7. The bowels are relaxed, and there are sometimes involuntary evacuations.

COMPRESSION.

1. An interval of a few minutes, or even of a quarter of an hour, sometimes elapses, especially if the compression is caused by extravasation of blood.
2. The power of speech is totally abolished; we may halloo in the patient's ear as loudly as possible, and yet there will be no response.
3. Special sensation is destroyed.
4. The respiration is slow, labored, stertorous, and performed with a peculiar blowing sound.
5. The pulse is labored, soft, irregular, and unnaturally slow, often beating not more than fifty, fifty-five, or sixty strokes in a minute.
6. The stomach is quiet, and insensible to ordinary impressions, even to emetics.
7. The bowels are torpid, and are with difficulty excited by the action of purgatives.

CONCUSSION.

8. The power of deglutition is impaired, but not abolished.

9. The bladder retains the power of expelling its contents; but sometimes, owing to the weakness of its sphincter, the water flows off involuntarily.

10. The voluntary muscles, although much weakened, are still able to contract, there being no paralysis.

11. The pupils are usually contracted, and somewhat sensible to light; the lids are open and movable.

12. In concussion, the mind is in a state of abeyance; it is weak and confused, not abolished.

COMPRESSION.

8. Deglutition is impossible, and sometimes does not return for several days.

9. The bladder is paralyzed, and, therefore, incapable of relieving itself, the surgeon being obliged to use the catheter.

10. There is always paralysis on one side of the body, generally opposite to that of the compressing cause.

11. The pupils are widely dilated, and unaffected by light, the lids being closed and immovable.

12. In compression, the patient is comatose, and the mind is temporarily abolished.

In regard to the differential diagnosis of contusion of the brain, there are no signs, so far as is at present known, by which this lesion can be distinguished from concussion of this organ, or concussion and the slighter forms of compression. L. J. Sanson, one of the editors of Dupuytren's works, lays great stress, in the milder varieties of contusion, upon the occurrence of spasmodic twitchings of some of the muscles of the face, the intolerance of light, the contraction of the pupils, and the partial but transient deafness; and, in the more severe, upon the suffused condition of the eyes, the intense restlessness and jactitation, the deep, circumscribed, pulsatile pain in the head, the convulsive movements of the limbs, the flexion of the fingers and toes, especially the former, the drowsiness and unconsciousness of the patient, and the absence of stertorous breathing. These phenomena, however, as has been conclusively shown by Fano and Hewett, are common to this and other lesions of the brain, and are, therefore, of no value whatever in a diagnostic point of view. The first group, indeed, is simply expressive of the milder forms of ordinary concussion, while the other, which rarely comes on before the fourth or fifth day, is clearly denotive of incipient inflammation of the brain, or of this organ and its envelops. Although it is thus evident that this lesion has no characteristic signs, it may, nevertheless, be assumed, as a rule, that the brain has been more or less violently contused when, after a blow or fall upon the head, the cerebral symptoms are unusually severe, protracted, or indisposed to yield to treatment.

The symptoms of these various affections of the brain are sometimes painfully simulated by those of *intoxication*, or it may be that one or more of them may coexist with intoxication, thus increasing the embarrassment. The diagnosis is to be deduced from the history of the case, the presence of external injury, particularly upon the scalp, the habits of the patient, and the state of the breath, which, in inebriation, will be alcoholic in its character. When doubt exists, the proper plan is to treat the case as one of cerebral disease, endeavoring, by suitable means, to bring on gradual reaction. A few hours will generally suffice to reveal the true nature of the affection, and this interval is not spent idly by the surgeon, but in a thorough examination of the body, with a view to the prompt detection and rectification of other injuries.

Compression of the brain from extravasated blood or depressed bone may be mistaken for *apoplexy*. Such an error may readily occur from a want of proper knowledge of the history of the case. Thus, a man may be found in the street in a state of insensibility, with all the ordinary phenomena of compression, no one knowing anything of the nature of his disorder, and the most critical examination of his body failing to throw any light upon it. There may not even be a scratch upon the scalp. The man dies, and inspection reveals the existence of a fracture with a large extravasation of blood. The symptoms of the two affections are, in fact, forcibly alike, and the error is really, practically, of no consequence, unless, as in the case of compression from external violence, the case be accessible to the trephine.

The unconsciousness produced by an overdose of *opium* might be mistaken for compression of the brain from external violence, especially if there be marks of injury of the scalp. The distinction between the two affections is founded mainly upon the condition of the pupil, which in narcotism from opium is greatly contracted, but widely dilated in cerebral compression from extravasated blood or depressed bone.

The distinction between compression from extravasated blood and compression from *inflammatory effusion* presents no obstacles. In the former case the cerebral symptoms show themselves either instantaneously or within a very short time of the receipt of the injury; whereas in the latter they are always preceded by those of encephalitis. Compression, depending upon fractures of the skull with depression of bone, is usually easily recognized by a careful examination of the head, the finger sinking down at the seat of injury, or detecting, more or less clearly, the irregularity of surface peculiar to such lesions.

In injury of the head the aid of the ophthalmoscope may sometimes be advantageously invoked, more especially when it involves the base of the skull and brain. In ordinary concussion the eye remains sound, but in fracture of the occipital and sphenoid bones, and in contusion of the brain with compression, it is not uncommon to meet with dilatation and thrombosis of the veins of the retina, with effusion of blood at the bottom of the eye, and with serous peripapillary infiltration. Similar appearances, with congestion and peripapillary œdema, occasionally occur as effects of encephalo-meningitis.

It would be interesting, certainly in a physiological point of view, if not also in a practical one, if we could determine, in these various traumatic lesions of the brain, the precise spot that is always affected; but for such a minute discrimination our present data are utterly insufficient. Nearly all that has been published upon the subject is based not upon facts, but upon conjecture, and is, therefore, destitute of any value.

Treatment.—The treatment of compression of the brain must be regulated by the nature of the exciting causes, as extravasated blood, depressed bone, foreign bodies, or inflammatory deposits.

1. *Extravasated Blood.*—The blood, in compression of the brain, may occupy the same localities as the matter in purulent effusion or abscess of the brain in encephalitis. Hence, as in the latter affection, it is only accessible in certain situations, as when it lies immediately beneath the inner surface of the cranium, or in the arachnoid sac, the membrane, perhaps, bulging through an opening left by a fracture of the skull, or made with the trephine in the hope of being able to evacuate it. It must not be forgotten that the most copious extravasations of blood sometimes occur without any apparent lesion whatever of the cranium, and such cases must, therefore, as a rule, be treated upon the same general principles as compression from effused blood in ordinary apoplexy. But as this subject will be fully discussed in the section on extravasation of blood from injury of the skull, any further comments upon it here would be out of place.

2. *Depressed Bone.*—Depression of bone may exist to a considerable extent without compression; but when it gives rise to this state, the symptoms come on immediately, and continue until the brain has either accommodated itself to its new relations, until the offending portion of bone has been removed, or until the patient dies from the effects of the injury. The lesion may be one purely of compression from depression of bone, or the accident may, as was previously intimated, be combined with extravasation of blood, caused by laceration of the cerebral or meningeal vessels, either by the offending bone or by the vulnerating body. In the latter case, the compression may be very violent, although the depression itself may be slight. The symptoms in this case, too, may, in the first instance, be imperfectly marked, those of concussion, perhaps, predominating over those of compression, but being speedily succeeded by the latter.

In the treatment of this form of compression, which will again come up for discussion in the remarks on fractures of the skull, no very definite rules can be laid down for the guidance of the surgeon. Every case must, so to speak, make its own rules. Practitioners are generally agreed that, when the compression is produced by depression of bone, attended with compound fracture, immediate recourse should be had to trephining, and such a procedure is certainly, it seems to me, the only one that ought to be thought of under the circumstances. In this way we not only remove the cause of compression, but place the parts in a much more favorable condition for speedy repair. The question is still an open one as it respects the treatment of compression from depression, attended with simple fracture. I am fully sensible of the difficulties of the subject, surrounded as it is by doubt and contradiction; but, after the best consideration that I can bestow upon it, I am disposed to regard operative interference as justifiable only in the event of extensive

depression, and I should adopt this plan whether the symptoms of compression were urgent or not, on the ground that the patient would be much less likely to suffer from subsequent cerebral disorder. When the depression is comparatively slight, and, especially, when there is no comminution of the bone, or great irregularity of its edges, giving them a rough, spiculated character, it would be well to let the bone alone, and to treat the case upon general principles, hoping thereby to prevent inflammatory mischief, and ultimate nervous irritation, which are so much to be dreaded in the more severe forms of the accident. There is a species of compression of the brain in children caused by extensive depression of bone without fracture, of which I have witnessed several remarkable examples, and which never requires operative interference. The bone is simply bent or indented, and usually, by its own resiliency, regains its natural level in a few days under the use of a little purgative medicine, light diet, and cold applications to the head.

γ. *Foreign Bodies*.—Compression of the brain by a foreign body is an unusual occurrence, and can hardly take place without some concomitant depression of the skull. A large ball, a piece of iron, or a splinter of wood lodging in the cranial cavity, in the cerebral substance, or in the ventricles, might produce the effect, accompanied, probably, by a pretty copious hemorrhage, thereby seriously complicating the lesion. The symptoms would be likely to be immediate, as in compression from depression of bone, and the treatment would manifestly resolve itself simply into the extraction of the extraneous body, care being taken, in doing this, to inflict as little injury as possible upon the surrounding structures, and to guard the brain and its membranes afterwards against inflammation. Such lesions must necessarily be fraught with danger, and will rarely be recovered from, however judiciously managed.

δ. *Effused Pus*.—An effusion of pus, or of pus and serum, giving rise to compression of the brain, can only occur as a secondary effect, coming on at a period varying, on an average, from a week to a fortnight from the commencement of the inflammation which precedes its development. Every practitioner, however, meets with cases where the interval is much longer, and to which we may, therefore, apply the term chronic. In general, the characteristic symptoms set in gradually, the disease bearing a great resemblance, in this respect, to the compression of the brain which follows arachnitis. There can, therefore, be no difficulty in discriminating between it and the other forms of compression already described, where the symptoms appear either immediately, or, at furthest, within a few minutes after the occurrence of the injury giving rise to the compression. At first there is evidence merely of inflammation; by and by, as the disease advances, effusion takes place, and now the chain of morbid action is completed by the supervention of coma, paralysis, convulsions, and death. This steady progressive movement, from one point to another, can leave no reasonable doubt respecting the true nature of the lesion, especially if it be coupled with a consideration of the history of the case.

In regard to instrumental interference in compression from inflammatory effusions, the same embarrassment is generally experienced as in compression from the extravasation of blood. The great difficulty is where to find the fluid, or, if found, how to evacuate it, so as to afford the patient a chance for his life. The result is that nearly every case of this kind must necessarily be fatal, neither trephining nor general treatment being of any ulterior avail. If, now and then, an instance of an opposite character occurs, it only serves to prove the rule.

4. IRRITATION OF THE BRAIN.

Injuries of the head are sometimes attended by a remarkable train of morbid phenomena, evidently due to irritation of the cerebral tissues, the characteristic sign being hyperæsthesia, or excessive sensibility, mental and corporeal. The affection is either primary, or, as is more frequently the case, it does not come on until several days after the occurrence of the accident. The most common exciting causes are blows, falls, and gunshot injuries of the head, eventuating in concussion of the brain, in contusion of the cerebral tissues, in fracture of the skull with slight depression, or in slight extravasations of blood, either into the substance of the brain, into the arachnoid sac, or between the dura mater and the inner surface of the cranium. A comparatively slight injury is often sufficient to induce it. Not

unfrequently it coexists with traumatic lesion of the spine. As a pure, uncomplicated affection, I doubt whether it ever takes place.

The patient, in this condition, is in a somnolent or semiconscious state, like a man partially under the influence of liquor; he is disposed to sleep, is excessively irritable, turns and twists about in bed, lies with his eyes closed, is roused with difficulty, answers abruptly and angrily when spoken to, and speedily lapses into his former condition; his pulse is feeble and calm, except when he is excited or annoyed, when it suddenly rises in force and frequency; the respiration is easy, and unaccompanied by stertor; the skin is moist, the countenance is pale, the stomach and bowels are natural, the urine is limpid, but passed with great frequency, and the control over the sphincter muscles is perfect. The posture in bed is peculiar. The body is curled up, the limbs are flexed, and the patient invariably lies upon his side. The hands are frequently tremulous, and the fingers are sometimes in constant motion. Muscular twitches of the face and extremities are not uncommon. The eyes are remarkably sensitive to light, and the lids are so firmly closed as to render it difficult to open them. The pupils are closely contracted. Marked delirium is often present.

In another class of cases, the patient is easily roused, and is perfectly sensible, answering questions coherently and rationally so long as his attention is kept awake, but relapsing as soon as he is left to himself, muttering as if his mind were occupied with some imaginary object, or engaged in some particular enterprise. A patient mentioned by Sir Astley Cooper, while in this condition, got out of his bed, lathered himself with his blistering salve, as he wished to shave himself, and washed his feet with lemonade in the chamber-pot. A patient of my own, a robust, healthy man, upwards of sixty years of age, labored for nearly four days, after a slight concussion of the brain, under all the symptoms of hysteria, attended with frequent paroxysms of laughter, and various mental illusions, along with great irritability of the bladder and an almost constant desire to void his urine.

Cerebral irritation is sometimes mainly characterized, as was long ago remarked by Velpeau, by stinging or pricking sensations in the head, by spasmodic twitchings of the muscles, especially of those of the face and eyes, by violent shooting or darting pains in different parts of the body, by convulsive tremors of the hands and fingers, and by anomalous paralytic phenomena; occurrences which, alternately increasing or diminishing, give the case the appearance at one time of impending death, and at another of approaching convalescence. The intelligence is generally preserved, but special sensation is often perverted. There is no coma, stupor, or lethargy.

Irritation of the brain occasionally arises from loss of blood, as after compound fractures attended with laceration of the organ and its meninges, the cerebral tissues not receiving a sufficiency of this fluid to enable it to perform its proper functions. The condition is generally easily recognized by muttering delirium, excessive pallor of the countenance, a suffused and wild expression of the eyes, throbbing of the carotid arteries, exquisite sensibility to light, a weak, irritable, and excitable pulse, a moist skin, intense thirst, and inability to sleep, with frequent moaning and sighing, and a disposition to faint.

Some of these conditions of the brain are occasionally closely simulated by mania-à-potu, and the difficulty of drawing a distinction between them is greatly augmented in the absence of a history of the case, or when a person habituated to the use of ardent spirit has met with an injury of the head.

The treatment of this class of affections must be conducted with great care and judgment. The danger mainly to be apprehended is from encephalo-meningitis, of which, in many cases, it is simply an exponent of the milder grades. The patient must, therefore, be watched with extraordinary vigilance, any tendency to overaction being promptly met by suitable measures. The more common cases will usually recover under very simple management, as perfect quietude of mind and body, exclusion of light and noise, cooling drinks, light diet, and an anodyne diaphoretic, as five grains of Dover's powder, or a little morphia in neutral mixture, every four or five hours; and, what often answers an excellent purpose, an occasional dose of thirty grains of bromide of potassium along with twenty grains of chloral. When the affection threatens to run into inflammation, or if inflammation already exist, more active measures will be demanded, as leeches to the temples, counter-irritation by blisters to the nape of the neck, active purgation, and other antiphlogistic

interrupted by unpleasant dreams, he has occasional fits of dizziness or vertigo, his pulse is too frequent, and he cannot apply himself with any satisfaction to his pursuits. Such is the usual prodrome of an event which has cost many a man his life. Mischief is stealthily going on in the brain, or in the brain and its membranes, which, if not promptly checked, soon bursts forth like the smothered flame of the incendiary's fire. In a little time the system is overwhelmed with excitement; soon delirium follows; then come coma and paralysis, and finally convulsions seal the sufferer's doom. Inspection reveals serious lesion of the brain and its envelops, with effusion of lymph and sero-purulent matter on the surface of the latter, and softening and, perhaps, abscess in the substance of the former.

The nature of this form of disease, to which the term subacute or chronic may very properly be applied, is, unfortunately, seldom recognized by the practitioner in time to afford his patient the necessary relief. He is generally disposed to make light of it, or it may be that he overlooks it altogether. When at length his suspicions are aroused, he finds to his horror that the case is utterly beyond the reach of his skill. Effusion has taken place, and death is inevitable.

The treatment of this secondary affection does not differ materially from that of the primary. As soon as it begins to show itself, the patient must be restricted to the most scrupulous antiphlogistic regimen, and submit to active and steady purgation, with the liberal use of tartrate of antimony and potassa. If head-symptoms exist, blood is taken from the arm and temple; rapid ptialism is aimed at; and counter-irritation is applied to the nape of the neck by blister, issue, or croton oil, its action being much more advantageous here than in the acute form of the malady. The treatment is continued for some time after all disease has apparently vanished, the patient slowly returning to his former habits and occupation.

6. ABSCESS OF THE BRAIN.

The matter that is poured out during the progress of encephalitis may, like extravasated blood, occupy different situations, and present itself either as pure pus, or in the form of pus, lymph, and serum, as when it occurs in the arachnoid sac, upon the surface of the brain, or within the ventricles. Not unfrequently the fluid, whatever it may be, is intermixed with blood, the direct result of the injury which has caused the inflammation. This may occur either as an effusion, properly so called, or as a distinct, circumscribed abscess, as when, for example, it occupies the substance of the brain.

One of the most common sites of the pus in traumatic encephalitis is the *subcranial*, or that in which, as the term implies, the fluid is lodged immediately below the inner surface of the skull, in a bag, as it were, formed by the detachment of the dura mater. Large accumulations occasionally form here, amounting to several ounces, especially when the case is somewhat of a chronic character. The fluid is generally thick, and of a yellow-greenish color. Cases occur in which it is very offensive, particularly when it has been long in forming, or when, as not unfrequently happens, it is associated with caries or necrosis of the corresponding portion of the cranial bone, or serious disease of the dura mater, as ulceration, softening, or gangrene.

When the matter is situated in the arachnoid sac, constituting what may be called the *intra-arachnoid* form of the disease, it is always intermixed with lymph and serum, the latter of which is often poured out in large quantities. The effusion is most common in the superior, anterior, and lateral portions of the brain; but it is also frequently met with at the base of the skull, especially after fractures in that situation. The occurrence is uncommon in the arachnoid sac of the cerebellum and the medulla oblongata. Sometimes pus, lymph, and serum are poured out in considerable quantity in the subarachnoid connective tissue. Pus is seldom found, at least not to any considerable extent, in the lateral ventricles of the brain, whereas an effusion of serum is very common there; usually constituting here, as when it occurs in connection with the arachnoid membrane on the surface of the organ, the chief cause of the cerebral trouble. When pus alone exists as the compressing agent, it will be found that it is generally situated either immediately beneath the skull, or in the anterior and middle lobes of the brain, which are, apparently, more liable to suffer in this way than any other portions of the organ. The cerebellum is seldom affected; and, as to the medulla oblongata, suppuration is among the most uncommon of its diseases.

When matter forms in the substance of the brain—the *intracerebral* variety of suppuration—it is usually collected into a circumscribed abscess, and is of a yellowish, grayish, or yellowish-white appearance, of moderately thick consistence, and destitute of odor, especially when it is of rapid development. The quantity is generally small, not exceeding, on an average, a few drachms. In cases of long standing, however, it may amount to several ounces. The cerebral tissue around is softened and disintegrated, or converted into a diffuent, pulaceous mass, and the minute vessels are distended with black blood. When the abscess is chronic, it is sometimes inclosed by a distinct cyst, of varying thickness and density, more or less vascular, and intimately adherent to the surrounding structures. When this is the case, it is possible that the pus is eventually absorbed, although more generally it remains in its confined situation, from the injurious effects caused by its presence. The matter, instead of being collected into an abscess, is occasionally infiltrated, as it were, into the cerebral substance, forming a number of minute points, hardly the size of a pin's head, of a pale yellowish color, interspersed through the softened and disorganized tissues. Both the white and the gray structures are subject to suppuration after injury; but experience has shown that the former is much more frequently affected than the latter.

There are no *symptoms* by which, in the existing state of the science, we can determine the precise situation which the matter occupies, the same difficulty existing, in forming an opinion, as in compression from extravasation of blood. It is only, as a general rule, when the matter lies immediately beneath the skull, and when the scalp or bone has sustained considerable injury, that even an approach can be made to anything like a correct diagnosis. When the pus is deeply buried in the substance of the brain, or lodged in the ventricles, there are no means by which its presence can be determined. We may, it is true, usually form a tolerably correct idea as to the side on which the effusion exists, by the hemiplegic condition of the body, the right side, for example, being paralyzed when the matter is seated on the left, and conversely; but to say whether it is situated in the substance of the brain or in its cavities, is an impossibility. In general, it may be assumed that the matter lies immediately beneath the skull when the compression arises from inflammation caused by a bruise or wound of the scalp; when, on the other hand, it follows concussion or fracture of the skull, it will be more likely to occupy the interior of the brain. To this statement, however, there are, of course, many exceptions.

The effusion of matter inducing this species of compression may be the result of concussion, sometimes so slight as hardly to attract any attention; of fracture of the skull, with or without extravasation of blood, and with or without depression of bone; and, finally, of injury of the scalp, in the form, perhaps, merely of a slight contusion or wound, yet sufficient to jar the skull, and detach the pericranium and the dura mater. It is very curious how an apparently trifling accident may sometimes give rise to the most serious consequences, destined to sweep everything before them. A man receives concussion of the brain; his suffering is altogether momentary, and he soon goes about his business; by and by, he begins to feel unwell, his head aches, he has no appetite, his bowels do not act properly, and he sleeps badly at night. Soon symptoms of inflammation of the brain set in, and thus the case progresses, from bad to worse, until effusion of pus takes place, followed by compression. Or, he has met with a fracture, perhaps quite insignificant; he gives himself no trouble about it, and may even entirely disregard the injunctions of his medical adviser. By and by, cerebral symptoms come on; the disease advances insidiously; treatment fails to relieve; matter forms, and the patient perishes from compression. Or, a little bruise has been inflicted upon the scalp, hardly perceptible to the eye, but still sufficient to injure the pericranium; in a few days erysipelas appears; gradually a small, puffy tumor forms; rigors, delirium, coma, and paralysis supervene, and the patient finally dies from a collection of pus between the skull and the dura mater, or beneath the dura mater, the inflammation having extended across the bone along the vessels and cellululo-fibrous connections. Or, lastly, the mischief may have been produced by a small wound of the scalp, the blow by which it was inflicted having, perhaps, detached both the pericranium and the dura mater. Again the case advances insidiously; the ill-boding rigor, delirium, stupor, and paralysis soon appear, and but too clearly indicate the formation of pus.

Abscess of the brain occasionally supervenes upon a surgical operation from injury inflicted during its performance upon the skull. Many years ago, I examined the

described. Cases of this kind are, in fact, not uncommon, and, as they are always remarkably insidious in their character, they are extremely liable to be overlooked. They are most apt to follow injuries of the skull and brain attended with concussion. After the symptoms of shock have passed off, the pulse either remains unnaturally slow, or if, as often happens, it becomes too frequent, it soon sinks again below the normal standard, beating, perhaps, only fifty, fifty-five, or, at most, sixty-five in the minute, at the same time that it is full and laboring. The mind is sluggish and fretful, the pupil is torpid and rather dilated, the countenance is more or less flushed, and the patient complains of headache, with ringing noises in the ear. If let alone, he gradually sinks into a comatose condition, followed by squinting and convulsions, and finally dies under symptoms denotive of cerebritis and hemorrhagic effusion. The blood often exists in large quantity, and in various degrees of consistence, much of it being quite soft and of a dark color, thus showing that it was poured out only a short time before death, in consequence, apparently, of the softened and lacerated condition of the cerebral tissues at the site of injury, and the inability of the vessels to protect themselves by the formation of firm clots.

In compression from depressed bone, the symptoms, as stated elsewhere, are immediate. The only exception to this rule is in slight depression, incapable, of itself, of producing compression, but, where this occurrence ensues from injury done to the soft parts, eventuating in effusion of blood, the two causes thus co-operating in bringing about the result. Moreover, extravasation may take place without fracture, or with fracture unattended with depression.

Treatment.—The treatment of this form of compression will depend upon the site of the effused blood, and the absence or presence of fracture of the skull. When the blood is accessible, it is obvious enough that it should be evacuated; but how is this to be known? How can it be determined whether it is situated immediately beneath the cranial bones, upon the hemispheres of the brain, at the base of the skull, in the cerebral substance, or within the ventricles? Are there any symptoms, any grand landmarks, which will serve to point out the spot where the compressing agent is lodged? The most subtle pathologist and diagnostician must be at fault here. Especially must this be the case when there is no fracture, or outward evidence of injury. Indeed, even when there is a fracture, we cannot always be certain. A person, to illustrate what I mean, has compression, and the symptoms render it pretty clear that it has been caused by extravasation of blood; there is no visible fracture, but a contusion on the scalp denotes where the injury was inflicted, and hemiplegia exists on the opposite side. Taking these facts in connection, the presumption is that the effusion is on the side of the brain where the head was hurt, and, acting upon this view, the surgeon, especially if he is fond of operating, may feel inclined to perforate the bone. But is he right in doing so? Possibly, he may find the object of his search; but he is groping in the dark, and there is quite as much likelihood that he may fail as that he may succeed. The blood may be far beyond his reach, and thus the patient may have been subjected to a fruitless and dangerous operation. Besides, it must not be forgotten that the blood may be at a point opposite to that upon which the blow has been inflicted. A surgeon makes occasionally a fortunate hit. Dr. Physick, in a case of this kind, boldly perforated the skull at the site of injury, and, extracting the clotted blood, cured his patient. But how often has the operation failed? Where one surgeon has succeeded, twenty have been disappointed. A judicious practitioner should have something more than mere conjecture to guide him in such an undertaking.

The truth is, the only case in which such a procedure is really warrantable is where the extravasation is associated with, or dependent upon, fracture of the skull, complicated with depression, or serious injury of the soft parts, or where the fracture is situated directly over the course of the middle meningeal artery. But even here the operation does not always succeed, as I know from personal observation. A boy, ten years old, was thrown off a heavy log, which, rolling over him, broke his skull directly over the right temple. The fracture, although not compound, was comminuted, and, as the symptoms were urgent, I made an incision through the scalp, raised a loose and slightly depressed piece of bone, and extracted a large coagulum. No relief followed; for, as fast as the blood was removed, the spacious osteo-membranous cavity filled up again, and I was finally compelled to close the wound, as best I could, with a compress and a tight roller, to prevent the boy from

bleeding to death. As it was, he died without return of consciousness in less than forty-eight hours.

Cases occasionally arise where, after the skull has been perforated, the blood is observed to be seated in the arachnoid sac, beneath the dura mater, lifting up this membrane in the form of a small, bluish swelling, beating synchronously with the left ventricle of the heart. In such a condition, the proper operation, it has been alleged, is to make an opening into the tumor, and let out its contents. But such a procedure must, it is obvious, seriously complicate the case, exposing the patient to the occurrence of inflammation and fungous protrusion, to leave out of the question the possibility, even in a minority of cases, of removing the clotted blood, or, after this has been effected, of preventing a fresh hemorrhage, perhaps quite as copious as the original. Little, if any, advantage is, I think, to be gained from such an undertaking, and, perhaps, it would be well, in view of its hazards, to refrain from it altogether.

Since, then, so little is to be accomplished by operation, how is the treatment of this affection to be conducted? Obviously, upon the same general principles as in ordinary apoplexy, from which, as has already been seen, compression from traumatic extravasation differs only in the absence of external injury, as, for example, laceration of the scalp and fracture of the cranial bones. The object is twofold: first, to enable the brain to accommodate itself to the effused blood, and, secondly, to promote the speedy absorption of this fluid. The first indication is fulfilled, after reaction is fully established, by copious general and local depletion, by the frequent use of active and rather drastic purgatives, and by the administration of saline and antimonial medicines, along with the use of light diet, cold applications to the head, and perfect quietude of mind and body. By these means, properly employed, the quantity of the blood is materially reduced both in the brain and in the general system, and, while the danger of inflammation is lessened, the organ is gradually brought to bear with the extraneous substance, no longer resenting its presence. Blood must not, however, be taken heedlessly or causelessly. No intelligent surgeon would bleed a patient before the system has thoroughly reacted. The same rules must govern us here, in the use of the lancet, as in exhaustion of the system from other causes. Premature abstraction of blood, in this form of compression and in apoplexy, has slain its thousands of subjects, or compelled the poor, crippled patient to drag out a miserable existence.

Mercury should be freely used at an early stage of the disease, as soon, indeed, as possible after thorough evacuation by the lancet and purgatives. It should be given in the form of calomel, in doses of three grains every six or eight hours, its action being assisted by inunction of the groins and inside of the thighs and arms with blue ointment. The gums must not merely be touched, but maintained in a tender condition for a number of weeks. When the case has become chronic, iodide of potassium takes the place of the mercurial, as there is now less need of hurry.

Throughout the treatment, the greatest vigilance must be exercised over the suffering organ, lest, in resenting the encroachment of the coagulum, it should take on inflammation, the slightest approach to which must instantly be met by the resumption of antiphlogistic measures.

Infants occasionally suffer from compression of the brain, from an effusion of blood beneath the dura mater, before the completion of the ossific process, induced by blows upon the head. The little patient lies in a state of insensibility, and is usually affected with convulsions or spasmodic twitches, and, perhaps, some degree of stertor. Considerable contusion of the scalp generally exists, but there is no fracture of the skull, because the bones are too yielding for such an occurrence, and the fontanel appears to be elevated somewhat above its proper level. Pressure made with the finger discovers unusual tension, and may aggravate the symptoms, especially the tendency to convulsions. Such a case is to be treated on general principles; with leeches and cold applications to the head, and stimulating injections, followed by a brisk purgative as soon as the power of deglutition returns. If these means fail, and the symptoms are very menacing, the duty of the surgeon plainly is to make a crucial incision through the scalp, and, dissecting up the angles of the flap, to puncture the distended, and, perhaps, purple-looking, membrane with the bistoury, taking care to make the aperture as small as may be consistent with the state of the extravasated blood, and to protect the parts, immediately after the evacuation has been effected, with adhesive strips, a compress, and a roller.

SECT. IV.—FRACTURES OF THE SKULL.

Fracture of the skull is a frequent occurrence, and is liable, even in comparatively slight cases, to be followed by the worst consequences. It may happen at any portion of the bony case, and may exhibit itself in a great variety of forms, from the merest fissure in the osseous surface to the most extensive loss of substance. In its character, the accident may be simple, compound, comminuted, depressed, or complicated. The import of these terms will be fully understood from what has been said respecting them in the chapter on fractures in general.

All fractures of the skull are the result of external violence, applied either directly to the part, or through the medium of the spinal column. It is remarkable how slight a blow will sometimes produce this injury. Several circumstances may be supposed to contribute to this result, of which the principal are the unusual thinness and brittleness of the cranial bones. It is by no means uncommon to see skulls which are so exceedingly thin as to be quite translucent, not at one point merely, but nearly through their entire extent. My collection contains several specimens, the walls of which are hardly half a line in thickness at the thickest part; they are, in fact, mere shells, composed of compact tissue, with hardly any trace of diploë. Such skulls are also, for the reason just stated, generally very brittle, although this property is by no means peculiar to them, but is often witnessed in comparatively thick crania. When unusual thinness and fragility coexist in a bone, it requires very little force to break it, either at the point struck, or at some opposite one. The fracture will, moreover, be likely to be uncommonly extensive, comminuted, and depressed. On the other hand, the skull may be so thick and hard as to be almost proof against force, however severe. In one of my specimens, the average thickness of the cranium is at least half an inch, its density is nearly equal to that of ivory, and hardly a trace is to be seen of a suture. To break such a skull, even in a comparatively slight degree, would require an amount of violence which is rarely inflicted under any circumstances.

The older authors, especially the members of the Royal Academy of Surgery of Paris, have a great deal to say about counter-fracture, a fracture occurring on one side of the head when the injury is inflicted upon the opposite one; and in reading their works one cannot fail to be impressed with the conviction that they must have considered it as a very common accident. That they were, however, in error upon this subject, modern experience has conclusively shown; and yet to deny altogether the possibility of such an occurrence, as some writers have done, is equally unfounded. Every surgeon in extensive practice must occasionally have met with cases of this kind. The accident is most common in the parietal bone, but it may also occur in the temporal and even in the occipital and frontal, the lesion always presenting itself in the form of a fissure, line, or crack, never as a fracture attended with depression. Fracture at the base of the skull is not, strictly speaking, a fracture by *contre-coup*, but the effect of two forces applied simultaneously at opposite points, as when, for example, a person falls from a considerable height and alights upon his head, the skull giving way at its base from the concentration of the injury by the joint agency of the blow and the weight of the body.

Fractures of the skull vary much in form and extent. The most frightful accidents of this kind are those in which the fracture involves a number of bones, travelling, perhaps, completely around the skull from the forehead to the occiput; or, as more frequently happens, from vertex to base, literally separating the anterior from the posterior part of the cranium, as in the cases reported by Luke, Chandler, and other surgeons.

The subject of fracture of the skull is an exceedingly complex one, and cannot be understood without the most careful and attentive study. The following arrangement will be found to comprise the most important divisions: 1. Simple fracture without depression: 2. Simple fracture with depression: 3. Simple fracture with displacement, and compression of the brain: 4. Compound fracture: 5. Fracture of the base of the skull: 6. Punctured fracture: and 7. Fracture of one table alone, either external or internal. Finally, there may be depression of the skull, sometimes, indeed, of a very marked character, without fracture, the cranial bones being bent rather than broken.

1. *Simple Linear Fracture with or without Contusion.*—The term simple, as applied to fracture of the skull, implies that the bone alone is involved, or that, if there be

any injury of the soft parts, it does not present itself in the form of an open wound. Some contusion of the scalp must of necessity always exist, however trifling or insignificant the osseous lesion. Such an occurrence constitutes a complication, but it is very different from a wound communicating with the seat of the fracture, and which, when present, renders the fracture compound. The most simple form in which fracture of the skull occurs is that of a crack or fissure, as in fig. 81, similar to what is observed in a broken pot. It is a mere solution of continuity of the osseous tissue, comparable, in many respects, to a simple incised wound. It is unattended with depression or the separation of any piece of bone. The fissure may involve the substance of the bone, or it may run along the course of the sutures, its extent varying from a few lines to several inches. It may be caused by direct violence, or, as occasionally happens, by contre-coup.

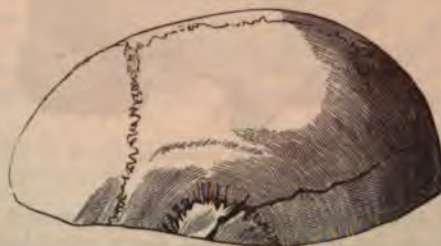
Such a fracture, provided there is no serious lesion of the soft parts, or of the brain, requires none but the most simple treatment. Rest for a short time in bed, an occasional purgative, rigid abstinence, and the avoidance of mental excitement, constitute the principal means of cure. The brain, of course, is carefully watched;

for the shock produced by the accident, causing more or less functional disturbance, may be followed by serious inflammation, and that, too, when, perhaps, it is least expected. Operative interference is not thought of; there being no depression of bone, and no extravasated blood to remove. The fissure gradually closes up by bony matter, without encroachment upon the inner table of the skull, and, consequently, without injury to its contents. In these cases, the older surgeons used to trephine, sometimes taking away large portions of the skull, and thus seriously complicating an injury which, at the present day, often gets well under the mildest means.

Mere *contusion* of the skull without fracture is frequently an accident of a very grave character, whether viewed with reference to its primary effects or its ulterior consequences. When the blow is very violent, as when it has been inflicted by a bludgeon or a partially spent ball, instant death may be produced by it, apparently from shock, or from shock and concussion of the cerebral tissues. In another class of cases, by no means uncommon, a large vessel on the inner surface of the skull may be ruptured, and such an amount of blood may be extravasated as to cause severe, if not fatal, compression. Sometimes blood is poured out into the arachnoid sac, or even into the substance of the brain. Cases have been observed in which the longitudinal sinus was laid open in contusion of the skull, and death was produced by the pressure of the effused blood. Encephalo-meningitis is a not infrequent occurrence after such accidents. Among the more remote effects are abscesses of the brain, and caries, necrosis, and exfoliation of the cranial bones. Such occurrences are more particularly liable to arise when there has been severe contusion of the diploë, leading to suppurative inflammation, not unfrequently followed by necrosis of both tables of the affected bone. Injuries of this kind, too, are very liable to give rise to pyæmia and to secondary abscesses in the lungs, liver, and other internal organs, from the direct entrance of pus into the circulation through the agency of the diploic veins. The treatment is similar to that of the simple fracture without depression, the great object being the prevention of encephalo-meningitis, and the promotion of cerebral accommodation.

2. *Simple Fracture with Depression of Bone.*—This form of fracture is not at all uncommon; the integument is more or less contused, and the patient is usually severely stunned by the blow or fall by which he has been hurt. The bone is found to be depressed, as in fig. 82, or driven beyond the surrounding level, but not sufficiently far to be productive of compression. If the injury has been very violent, the bone may be comminuted, and some of the pieces may be partially detached, pressing, perhaps, against the dura mater. The great danger from such an accident, after reaction has taken place, is inflammation of the cranial contents, and, remotely, nervous irritation, followed by epilepsy, if not epilepsy and fatuity. The question

Fig. 81.



Simple Fracture of the Skull.

Fig. 82.



Fracture with Depression

then arises, how shall it be treated? Upon this subject, surgeons have been much divided in opinion, some favoring, others condemning, operative interference; favoring, because of the dreaded primary and secondary effects; condemning, because a simple fracture is thus converted into a compound one. Avoiding both these extremes, as calculated, if fully carried out, to be followed by mischievous consequences, the judicious practitioner will be governed, in the choice of his remedies, by the circumstances of each individual case. When the fracture is of small extent, free from comminution, and without much depression, the best plan will be not to attempt elevation, but to treat the patient upon general principles, using depletion by the lancet and other means, with a view

to the prevention of inflammation and other evil consequences. If, on the other hand, the bone is forced down considerably, so as to impinge very decidedly upon the brain, or if it be comminuted or jagged at the edges, the sooner it is raised or removed the better; since, if it be allowed to remain, it cannot fail to become a source of trouble, either by exciting inflammation, or by causing unpleasant secondary effects. I am fully, indeed painfully, sensible of the responsibility which I incur in giving this advice; but I feel satisfied, after mature consideration, aided by the light of experience, that it is the best, if not the only proper, course to be pursued under the circumstances. A man laboring under such an affection is never free from danger; he may get well, or be well to all appearance, and yet be only partially cured, subject, at any moment, to have his mind and life imperilled by the broken bone. It is like the sword of the tyrant suspended over the head of his subject.

3. *Simple Fracture with Depression, and Symptoms of Compression.*—In this variety of fracture, the bone is not only displaced, but sunk so far below its natural level as to produce compression of the brain. The patient lies in a comatose condition, breathing heavily and stertorously, with dilated pupil, and a slow, laboring pulse, the side opposite the seat of injury being paralyzed. The symptoms are unmistakable. The fractured and depressed bone, with, perhaps, slight sanguineous effusion, is the cause of trouble. The case, although different from the preceding, has yet much in common with it, the cerebral compression constituting the main feature in the dissimilarity. Here, too, the treatment is not settled, some contending for delay, others for immediate action; the former hoping, by depletion and other means, for cerebral accommodation and prevention of inflammation; the latter trusting, by operative measures, to prevent both present and future evil. Unfortunately, experience, always the best guide in such matters, has not fully decided the question as to which of these two plans should be preferred. Much has been said on both sides; but I am decidedly in favor of immediate trephining, on the ground that, while the operation adds but little to the risk of the case, the patient has a much better chance of prompt recovery. As long as the bone is depressed, even supposing that the compression is removed, there is danger of inflammation of the brain and its envelops, to say nothing of the occurrence of epilepsy and other nervous affections, as distressing to the patient as they are embarrassing to the practitioner. My opinion, then, is that operative interference, early and efficient, is, as a rule, the only proper plan to be pursued under such circumstances. I am sure I should prefer such a course in my own case, if, after all the facts on both sides of the question had been fairly stated to me, I had sufficient judgment left to determine my choice.

4. *Compound Fracture.*—A fracture of the skull is said to be compound when the injury of the bone is associated with a wound in the scalp, communicating with the fissure in the bone. Such a fracture may be comminuted or depressed, or both comminuted and depressed, and attended with or without compression of the brain. The scalp is frequently much contused and ecchymosed, and a good deal of swelling generally arises soon after the occurrence of the injury. The symptoms may be those merely of shock, perhaps severe and protracted, or concussion and compression

may coexist, commencing simultaneously, and running on, step by step, until reaction ensues, or until the case terminates in sinking. Hemorrhage, occasionally quite copious and protracted, may attend the accident, adding thus to the exhaustion of the already enfeebled frame.

The danger of compound fracture of the skull is threefold, from shock, from inflammation, and from fungus of the brain. When the violence to the bone and soft parts has been unusually severe, death may occur without reaction, or after a feeble and unsuccessful show at restoration; or, the first symptoms having passed off, life may be assailed by inflammation; or, this being happily surmounted, the patient may perish from fungus of the brain. When the fracture is very extensive, and is accompanied with great laceration of the dura mater, death may occur from sheer loss of cerebral substance, as in a case under my observation in 1852. The patient, a little girl, nearly three years of age, had received a blow from a brick, which literally mashed the top of the cranium, causing extensive laceration of the dura mater, through which the disorganized brain escaped in immense quantity, despite the efforts to prevent it.

The proper *treatment* in compound fracture is to elevate the depressed bone, and to remove any loose or partially detached pieces, this plan being adopted whether there be any symptoms of compression or not. The case, being a compound one, cannot be aggravated by operation, although it is not to be forgotten that this should be executed with the greatest care and gentleness. The operation is done at once, while the parts are still fresh from the first effects of the injury, and, consequently, prior to the supervention of inflammation. Elevation and retention of the depressed fragments are effected whenever this is practicable, but all loose pieces are removed, as well as such as are nearly detached, lest they should become a source of irritation, either present or future, by acting as foreign bodies. In the compound, comminuted fracture, I have, on several occasions, been compelled to take away an extraordinary quantity of bone, fully equal in size to that of the palm of the hand, and yet recovery followed in almost every instance. The danger of such a procedure is probably not so great as is generally imagined, provided there is no lesion of the brain and its envelops. When these structures are wounded, the case assumes at once a grave character, as there is then risk not only of violent inflammation, but also of loss of cerebral substance and of the ultimate formation of fungus; two circumstances which cannot be too much dreaded. I am averse to the retention of any piece of bone, however large, that has lost all connection with the surrounding parts, believing that its reunion, even if it were possible, which, however, it rarely is, would, from the irregularity of the provisional callus, almost inevitably become a source of mischief, leading perhaps, at length, to the necessity of trephining. Whenever such a procedure is required, due support must be given to the now unprotected brain by sheet lead, compress and bandage, otherwise there may be extensive protrusion of the cerebral pulp before the surgeon is aware of it, the brain rising and tending to escape at every pulsation of the heart. I have found it extremely difficult, in several instances, successfully to counteract this tendency by any means that could be adopted, and the consequence was that the patient soon fell into convulsions, speedily followed by death.

The offending bone having been raised, or removed, the edges of the wound are gently approximated by suture and plaster, the whole being supported by a compress and roller. The head, previously well shaved, is maintained in an elevated position, and kept constantly wet with cold water, or, what is better, a bladder partially filled with pounded ice, or some refrigerant lotion. If the patient is young and plethoric, and there has been no serious hemorrhage, blood is taken freely from the arm, and by leeches from the temple, the bowels are thoroughly moved by drastic purgatives, and the heart's action is equalized by antimonial and saline preparations, aided by the moderate use of opiates and veratrum viride. Light and noise are excluded from the apartment, and the diet is of the mildest and simplest character, consisting of a little panada, thin gruel, or arrowroot, along with acidulated drinks.

5. *Fracture of the Base of the Skull.*—Fracture of the base of the skull may be perfectly simple; mild symptoms characterizing the affection, and mild remedies sufficing for its relief. But it is far otherwise when the fissure is extensive, owing to the lesion sustained by the brain and its envelops, the former being often severely concussed, and the latter freely detached, large quantities of blood being at the same time frequently extravasated at the site of injury, either in the arachnoid sac or

beneath the dura mater. The accident is usually caused by falls upon the vertex, or by the head being crushed laterally, as by the passage of the wheel of a carriage, or by the head being jammed in between two hard and resisting bodies, as a post and a railway car. A fall upon the buttocks, knees, or feet may also produce this fracture, but such an occurrence must be extremely rare, and will only be likely to happen when the cranial bones are uncommonly thin and brittle. In most of the cases of this fracture that have come under my observation, the injury was occasioned by the person pitching, head foremost, from a second story window or a high scaffolding down upon the pavement, the weight of the body being received upon the vertex. In a remarkable instance of this kind, which was treated in 1846 by Professor T. G. Richardson, and which I had an opportunity of seeing soon after the occurrence of the accident, the fracture extended in a circle around the occipital, sphenoid, temporal, and frontal bones, separating them completely from the rest of the skull. The man had been pushed down a high flight of stairs, and in the fall had struck his head violently against the floor. He was immediately picked up in a state of insensibility, in which he continued, without any successful attempt at reaction, until he died, about forty-eight hours afterwards. Dissection showed not only the frightful extent of fracture here indicated, but an immense coagulum at the base of the skull.

The adjoining cut, fig. 83, affords an excellent illustration of the form of fracture now described. It will be observed that the occipital, temporal, and sphenoid bones are most extensively fissured, the injury having been occasioned by a fall upon the vertex.

Fig. 83.



Fracture of the Base of the Skull.

Chassaignac and Hewett have each related an instance in which a direct fracture of the base of the skull occurred by the forcible projection of the condyle of the lower jaw against the glenoid cavity of the temporal bone. In the case of the French surgeon, the bone pressed upon the middle lobe of the brain, in which there was a large abscess, causing death between five and six months after the receipt of the injury.

It is, then, not so much on account of the fracture, as of the great mischief inflicted upon the soft parts, the brain in particular, that this injury is so justly dreaded by the intelligent surgeon. The moment he sees his patient, he is fully impressed with the critical nature of his condition. The symptoms are always of the worst possible description. They are invariably those of concussion and compression, the latter coming on early, and usually continuing, with little or no mitigation, until the close of life. The countenance is deadly pale, the pulse is feeble and hardly perceptible, the respiration is nearly extinct, the pupils are widely dilated, and there is not the slightest sign of sensibility of any kind. Blood often issues from the ears, nose, and mouth, from some of the vessels in these parts having given way, in consequence of the severity of the blow or fall inflicting the injury. Occasionally the bleeding from the ears is quite copious, especially when there is fracture of the petrous portion of the temporal bone, and sometimes even when there is merely a rupture of the membrane of the tympanum. Now and then the blood proceeds from the interior of the skull through a crack in the cranium communicating with the nose, the mouth, and the orbit of the eye, the fluid, in the latter case, sometimes discoloring the conjunctiva and perhaps even the lids. There is also occasionally, as was first shown by Dolbeau, ecchymosis of the posterior wall of the pharynx, extending from the occipital bone to the upper cervical vertebræ, but difficult to be seen, as it is generally concealed by the palate. Fracture of the petrous portion of the temporal bone with laceration of the drum of the ear is sometimes attended with an escape of air-bubbles.

When the ethmoid and temporal bones are severely crushed, large fissures may be formed at the base of the skull, admitting of the discharge of a considerable quan-

tity of brain through the ear and nose, along with more or less blood and cephalo-spinal fluid.

An escape of serosity from the ears is occasionally observed, and great stress is justly laid upon it on account of its diagnostic value. This singular occurrence, already indicated by Berengario and Van der Wiel, and indistinctly shadowed forth in the writings of O'Halloran, Dease, and others, was first correctly interpreted by Laugier and Robert, in a memoir published upon the subject in 1846. The discharge generally begins within a short time after the accident, and after having continued, often quite profusely, for several days, gradually vanishes. It seldom proceeds from both ears, even in the more severe grades of fracture, and is not necessarily accompanied or followed by deafness. The escape, which is commonly continuous, is sometimes accelerated by a prolonged or forced expiration. The fluid, at first red from the admixture of blood, soon assumes a clear, limpid appearance, and usually so remains until it finally ceases. The quantity varies in different cases and in different circumstances. As many as three, four, and even five ounces may be lost in the twenty-four hours, the fluid dropping upon and saturating the patient's pillow. In the remarkable case published, in 1727, by Van der Wiel, the discharge, consequent upon a severe fracture of the base of the skull, was truly enormous, and continued almost uninterruptedly for five days. The fluid, always strongly saline in its taste, from the presence of chloride of sodium, is of a clear, watery aspect and consistence, and is entirely destitute of coagulability, exhibiting merely a trace of albumen, and differing, therefore, essentially from ordinary serum. Chatin, in analyzing it, found its composition to be identical with that of the cephalo-spinal liquid; and Bernard has ascertained the additional fact that both fluids contain a small quantity of sugar.

The source of this discharge has been variously explained. By some, it has been supposed to be derived from the serum of the blood that is so abundantly poured out in fracture of the base of the skull; one writer has expressed the opinion that it is furnished by the large venous sinuses connected with the petrous portion of the temporal bone; while several observers have declared that it is merely an inordinate secretion of the liquor of Cotunnus. All these notions are incorrect. The fluid, as is now universally admitted, is simply cephalo-spinal liquid, the evacuation of which, by the ear, is due to a rent in the cul-de-sac of the arachnoid membrane which is prolonged around the auditory nerve as it passes along the auditory canal in the petrous portion of the temporal bone. This view of the case is fully corroborated by the similarity in the physical and chemical properties of the two fluids, and by the fact that the serous investment of the brain has been repeatedly found to be torn completely across, opposite the outlet at which the escape has been observed to take place. The discharge, usually most abundant in young, vigorous subjects, is equally common at all periods of life.

An escape of cerebro-spinal fluid may accompany almost any fracture of the skull, apart from that of the petrous portion of the temporal bone, when there is a laceration of the arachnoid membrane. The occurrence has been noticed in fracture at the vertex, but is most common in lesions of the occipital region. In a case reported by Mr. Henry Gray, of London, the fluid evidently proceeded from the inflamed membrane of the middle ear, as there was no fracture of the temporal bone; and in another, observed by Mr. Holmes, of St. George's Hospital, the discharge was due to a fracture of the lower jaw, one of the fragments of which had perforated the wall of the auditory passage.

Facial paralysis on the side of the fracture is an occasional symptom, caused either by direct injury of the portio dura, or by inflammation of its substance and of the parts around, interfering with the transmission of nerve-fluid. In the former case the paralysis is generally immediate, whereas in the latter it seldom manifests itself under several days. It may occur without any escape of cerebro-spinal fluid, and is always a symptom of great diagnostic value.

Paralysis of the face, as was originally pointed out by Monteau and Blandin, not unfrequently coexists with paralysis of the uvula and the palate, evidently due to the injury sustained by the filaments of the sphenopalatine ganglion that are distributed to these structures. This coincidence is so much the more valuable, diagnostically considered, because it only occurs when the injury which gives rise to it is seated within the cranium, close to the petrous portion of the temporal bone.

When there is paralysis of the face alone, without paralysis of the palate and uvula, it may be assumed that the lesion is external, or in the peripheral branches of the facial nerve.

The diagnosis of fracture at the base of the skull is not as difficult as is generally supposed. The history of the case, the coexistence of violent concussion and compression, the profound coma and insensibility, the absence of fracture at the more accessible portions of the cranium, and the obstinate persistence of the symptoms, are, in most cases, sufficiently declarative of the nature of the accident. The inferences derived from these sources will be materially strengthened, if there be at the same time a discharge of blood from the ears, profuse and continued, as it will be likely to be when there is fracture of the petrous portion of the temporal bone. A flow of serosity from these passages is an infrequent, but, diagnostically considered, a most valuable occurrence, as it always affords indubitable evidence of the lesion in question. The same is true of the discharge of cerebral matter from the nose and ears, and of the existence of facial paralysis. Bleeding from the nose and mouth and discoloration of the conjunctiva and eyelids may proceed from other causes, and are, therefore, of no diagnostic value.

Fracture at the base of the skull is one of the most serious of accidents. If it do not always terminate fatally, the number of recoveries is so few as to form merely an exception to a law which is by many regarded, and very justly so, as general. I have myself, out of at least a dozen cases of the kind, witnessed only one restoration. That the injury should usually end in this way is not surprising, when we reflect upon its violent and complicated character, and upon the fact that, under any circumstances, hardly anything is to be effected by treatment, which is obliged to be altogether expectant. Operative interference is, of course, wholly out of the question. The only thing to be done, in the first instance, is to endeavor to establish reaction, and, if this should fortunately take place, afterwards to employ means for averting inflammation. In most of the cases that have come under my observation, the patient never recovered from the unconscious and exhausted condition consequent upon the first blow, death having usually occurred before the end of the third day.

Although this fracture is generally fatal, yet occasionally recovery occurs in a case, apparently, of the most desperate character, as in one recently observed by Professor Armsby, of Albany, in which, in addition to arterial and venous hemorrhage, there was a discharge of cerebral substance from the right ear, indicative of extensive injury of the petrous portion of the temporal bone and of the membranes of the brain. The patient at the end of three weeks was able to go about, his mental faculties, however, being still considerably impaired.

Several cases have been reported in which, after recovery from fracture of the base of the skull, the patient became affected with pneumatocele at the posterior part of the head, evidently due to an escape of air from the middle ear through a crevice in the petrous portion of the temporal bone. The tumor is usually small, of an irregularly spherical shape, soft, elastic, painless, resonant, and effaceable by pressure. The treatment, as stated in the section on affections of the cranial bones, is best conducted by systematic compression.

6. *Punctured Fracture*.—A punctured fracture is a small, circumscribed opening in the skull, attended with depression of both tables, the inner, however, being always more displaced, as well as more badly broken, than the outer. It derives its name from its size, which is often quite insignificant, and from the circumstance that it is invariably produced by a narrow weapon, as a poker, bayonet, ball, or dirk. It is sometimes caused by a fall upon a nail, a sharp stone, or the top of an iron railing; and I have seen several cases where it was produced by a blow with a hammer, hatchet, or brick, the angle striking the bone. From the manner in which the injury is inflicted, there is always necessarily severe contusion of the scalp, if not laceration of its entire thickness, constituting, in the latter case, a compound fracture.

The annexed drawing, fig. 84, from a preparation in my collection, affords an excellent idea of the nature of this variety of fracture. The case was neglected or mismanaged, and the man died in three weeks from abscess of the anterior lobe of the brain, caused by the pressure of the depressed bone.

Punctured fracture is not often attended with compression; for, although the inner table of the cranium may be considerably depressed, there are few cases where it causes such an amount of pressure as to produce this effect. Sometimes a sharp spicule of

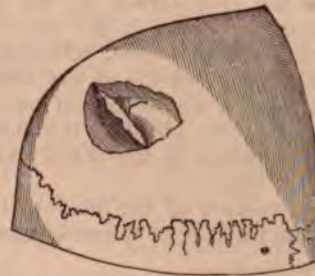
bone dips down into the membranes of the brain, and even into its substance, sadly complicating the case. The accident is always easily recognized by inspection and digital exploration, aided, if necessary, by the probe, the latter often affording important information relative to the nature and extent of the depression. However simple, a punctured fracture of the skull should always be regarded as a most serious lesion, from which, unless it is properly understood and treated, few persons ever make a happy escape. The great danger is inflammation of the brain and its membranes, frequently coming on within a few days after the accident, and sure to terminate fatally, if the case has been neglected or mismanaged. Should the patient be so fortunate as to escape with his life, he can scarcely fail to suffer afterwards from cerebral irritation, especially epilepsy and mental imbecility. In view of these occurrences, practitioners have long been agreed that the proper treatment is trephining, performed at the earliest possible moment, and without the slightest regard whatever to the character of the head symptoms; or, in other words, as to whether there is compression or not.

It is sometimes very difficult to persuade a patient, when there is merely a little hole in his cranium, without pain, headache, or any other symptom of consequence, to submit to what he may regard as so serious an operation as that of boring the skull. A case forcibly illustrative of this fact came under my observation, many years ago, in a man who lost his life from this cause. The fracture, inflicted with a brick, was situated at the middle of the left parietal bone. He was stunned for a few minutes by the blow, but soon recovering, he immediately mounted his horse, and rode to my house, a distance of nearly two miles. Upon his arrival, he was in every respect comfortable, except that he complained of a little soreness of the scalp. Discovering the nature of the fracture, I pointed out to him very fully its dangers, and begged him to submit without delay to an operation for his relief. To this, however, he refused to consent, and I accordingly dismissed him, having previously enjoined absolute rest, a purgative, light diet, and constant elevation of the head, with cold water-dressing. Two days afterwards, when I was sent for, I found him very feverish, with a tendency to delirium. Again an operation was urged, and again declined. He grew gradually worse, and on the seventh day, when he was in a comatose condition, I was permitted to use the trephine. No relief followed the operation, and he died in thirty-six hours. Pus and lymph were found at the seat of the injury, along with slight softening of the brain, and the lateral ventricles contained several ounces of serum. Who can doubt that this man lost his life by his obstinacy and folly? If he had been immediately trephined, there is reason to believe that he would have made a speedy and perfect recovery.

7. *Fracture of only one of the Tables.*—Fracture of the external table alone of the skull is extremely uncommon, and can happen only in the adult, or in persons whose cranial bones have a distinct diploë. Moreover, its occurrence implies unusual brittleness of the outer table, and inordinate firmness of the inner. The fracture is generally of small extent, and the depression inconsiderable. The most common cause is a blow from a narrow, blunt-pointed body. Besides being momentarily stunned, the patient suffers no particular inconvenience, save what results from the scalp lesion. The diagnosis of such a fracture must necessarily be obscure, and, unless great care be taken, it might easily be confounded with an ordinary punctured fracture. Mistake will best be avoided, in case of wound, by the careful use of a fine probe, carried around the edge of the depressed bone, by the pressure of the finger, and by filling the artificial hollow with water. If the probe enter any side crevices, the finger cause motion, or the water disappear, there will be reason to conclude that the fracture involves both tables of the bone, and that it is of a punctured nature. The injury requires no particular treatment, apart from that which may be necessary on account of the lesion of the scalp and brain.

The external table of the skull is sometimes broken by force applied to the internal surface of the bone, as when a bullet, discharged through the mouth, traverses the brain, and strikes the cranium without penetrating its substance.

Fig. 84.



Punctured Fracture of the Skull.

In a case of this kind, related by Mr. Teevan, of London, there was no fracture at the spot struck by the missile, but a fissured fracture existed at the corresponding point in the external table. It would seem, as remarked by the narrator of this case, hitherto unique in the annals of surgery, that, whether the inside or outside of the skull be struck, fracture of the distal table only, without injury to the proximal one, can be produced in either event, in obedience to a well-known physical law that the solution of continuity begins in the line of extension, which is the distal side, and not in that of compression, which is the proximal one.

Fracture of the internal table alone, fig. 85, is, if possible, still more uncommon than fracture of the outer one, and, as the accident is chiefly, if not exclusively, caused by gunshot injury, it necessarily falls to be considered under that head. However induced, the lesion is seldom discovered until after death, and then, perhaps, only accidentally, as it does not give rise to any marked, much less characteristic, symptoms. When it is suspected to exist, and especially when there is concomitant compression, the proper remedy would be the trephine, for the same reason that this operation is performed in punctured fracture.

Fig. 85.



Fracture of the Inner Table of the Skull.

8. *Depression without Fracture.*—Depression of the cranial bones without fracture can take place only in very young subjects, before the completion of the ossific process. It is a bending rather than a fracture of the osseous fibres, and is confined chiefly, if not entirely, to the frontal, parietal, and occipital bones. It is usually produced by a fall from a considerable height, in which the child alights upon the top of the skull, which is sometimes flattened in a most grotesque manner, and in a most extraordinary degree. I have seen only three instances of this occurrence, one of which made a great impression upon me at the time, on account of its novelty and extent. It happened in a child two years and a few months old, who, in falling down a long flight of stairs, struck its head violently against the floor. It was picked up in a state of insensibility, and, for a few minutes, it was supposed to be dead. Signs of reanimation, however, soon appeared, and in a few hours the reaction was perfect. The anterior and upper portion of the skull was completely flattened, the frontal and parietal bones being pressed out in such a manner as to give the head a most singularly deformed appearance. The child lay for the better part of a day in a comatose condition, with frequent spasmodic twitches, but no decided convulsions; both pupils were dilated, but not altogether insensible to light; and the pulse, after the subsidence of the shock consequent upon the fall, was slow and labored. Under mild treatment, these symptoms gradually disappeared as the depressed bones regained their natural level, as they did in less than a week from the time of the accident. In another case, the depression was much less, and the effect proportionately milder. In the *American Journal of the Medical Sciences* for August, 1840, a very extraordinary instance of this accident is related by one of my former pupils, Dr. Burt, of the Navy. A child, three years old, fell out of a second-story window, head foremost, upon the pavement below, a distance of sixteen feet, knocking the skull as flat as a board, the frontal bone projecting two inches over the eyebrows. For an hour the child had symptoms of violent concussion, when slight convulsions came on, followed by vomiting, which afforded great relief. The treatment consisted of cold applications to the head and of gentle cathartics. No fracture could be detected. The bone speedily began to resume its natural position, and in a short time the skull had regained its former shape.

Depression of the skull unaccompanied by fracture occasionally exists without any serious symptoms. Thus, in a case reported by Green, the patient experienced no particular inconvenience, although the hollow in the bone was sufficiently deep to receive the bowl of a desertspoon.

In cases similar to those now mentioned, the treatment resolves itself into the adoption of the most gentle measures, as leeches and cold applications to the head, purgatives, and stimulating enemata. If the patient is very plethoric, blood may

be taken from the arm, but this will generally be unnecessary. The bone gradually resumes its natural position, by its own resilient powers and the pulsatory movements of the brain. All interference with the trephine is, of course, avoided.

If the child be very young, an attempt may be made to raise the bone by suction with a cupping-glass, as recommended by Paré and Hildanus, and practised successfully, in 1849, by Dr. W. L. Moultrie, of Charleston. The depression, in this case, occupied the parietal bone, and was large enough to contain with ease the bowl of a common tablespoon. The instrument having been properly adjusted and exhausted of air, traction was made upon it, with the effect of rapid and complete restoration of the entire surface to its natural level. The child, which was five months old, recovered without any untoward symptom. A case of a similar nature has been reported by Dr. Nicolls, in the *Dublin Medical Press* for September, 1853. The depression, which was deep, narrow, and about three inches in length, was promptly raised by a cupping-glass placed upon an embankment of common glazier's putty, in order to afford the instrument a proper purchase. The child was two years old.

9. *Fracture of the Frontal Sinuses.*—This accident may happen from any of the causes that give rise to fracture of the skull generally, as blows, falls, pointed weapons, or gunshot injury; and in their character they may be simple, compound, or comminuted, with or without depression. Children are not subject to such lesions, as these cavities are absent in early life, or only very slightly developed. One of the great peculiarities of fracture in this situation is an escape of air, particularly noticeable in blowing the nose, when it often passes out with a distinct whizzing noise. When the bone is depressed, and there is no external opening, the air collects in the cellular tissue beneath the skin, forming a characteristic, crackling swelling, which occasionally occupies a considerable portion of the neighboring structures, as the forehead, eyebrow, eyelid, and even the root of the nose. The reason why it never extends over the entire scalp is the extraordinary density and firmness of the cellular substance in this situation. The occurrence of emphysema in fracture of the frontal sinuses is readily accounted for by the communication which naturally exists between this cavity and the nose.

The treatment of fracture in this region of the skull presents nothing peculiar. Depressed bone, in view of the deformity which it must inevitably cause if left to itself, should always be promptly elevated, even when there is no wound in the skin, as it never resumes its natural position spontaneously, and no possible harm can arise from the use of the knife, the brain being entirely out of the way. The emphysema usually in a short time disappears of its own accord, or under the usual remedies. Fistulous openings sometimes remain after such injuries. These are to be managed upon ordinary principles, a plastic operation being occasionally required to effect their permanent obliteration.

In a case of compound fracture of the frontal sinus which I attended along with Dr. Ronalds, in a child eight years old, the outer table of the bone was broken at several points, and knocked considerably below the natural level. A wound, one inch long, existed on the left eyebrow. In attempting to raise the depressed bone, which I succeeded in doing with a delicate and slightly curved awl, the boy had a violent convulsion, but from this he soon recovered, and he had no bad symptoms afterwards.

10. *Separation of the Sutures.*—This accident is uncommon. It may exist as an independent lesion, or, as is more frequently the case, in association with more or less extensive fracture of the adjacent bones. Sometimes, indeed, nearly all the pieces of the cranium are broken and even comminuted, as when the injury is caused by a cannon ball, by a fall from a great height, by the kick of a horse, or by great and continuous compression, as when the head is forced in between two hard and resisting bodies. The sutures most liable to suffer in this manner are the sagittal and coronal. However induced, the symptoms are usually of a blended character, denotive both of concussion and compression. Very frequently there is copious hemorrhage from the ears, with extensive ecchymosis of the scalp and conjunctiva. The prognosis is unfavorable. Death may occur almost instantaneously, or, at all events, within a few hours after the accident, with little, if any, effort at reaction. When the patient lives for several days, the post-mortem inspection invariably reveals all the usual evidences of inflammation of the brain and its membranes.

The treatment does not differ from that of ordinary injuries of the skull. The

first object is to promote reaction, and the second to prevent inflammation, the danger of which is generally very imminent in all cases where the patient survives the primary effects of the accident. Restoration of the displaced bones is not always practicable, and the attempts to accomplish it must be conducted in the most cautious manner, the chief agent being manual and digital pressure, conjoined with the bandage.

11. *Apparent Depression.*—The practitioner is sometimes sorely puzzled to determine whether what he sees and feels upon the skull is really a depression of the bone or merely a deceptive appearance. Of this occurrence I have seen several well marked instances, and, as it is by no means uncommon, it is very important that we should be acquainted with its true character, lest we be tempted to use the trephine in cases which will either yield to very slight treatment, or where, from the injury done to the brain, treatment of every description is hopeless. The manner in which it is produced is easily understood. A man receives a blow or fall upon the head severely contusing the scalp, and, perhaps, inflicting serious injury upon the cranial contents. Upon examination, a tumor is found, having a depressed centre and elevated edges, its size, perhaps, equalling the palm of a small hand. The depression indicating the spot upon which the violence was concentrated, is due solely to the condensation of the tissues of the part; while the tumor itself is caused by the blood that is extravasated at the time of the accident, and which now distends the cells of the adjacent structures.

The first case in which I noticed this occurrence was that of an elderly man, who was picked up in a state of coma from a fall which he had received a short time previously from a second-story window upon the pavement below. The tumor, which was uncommonly large, existed upon the right side of the head, over the parietal protuberance; its edges were remarkably prominent and well defined, and the central cavity felt precisely as if it had been caused by a fracture with depression of the bone. A careful examination, however, satisfied me that the appearance was altogether deceptive, and the death of the man, nine hours afterwards, confirmed the accuracy of my diagnosis. The parietal bone was perfectly sound, but one of the most extensive fractures that I have ever seen existed at the base of the skull, along with an immense effusion of blood.

A boy, sixteen years of age, in riding rapidly around a race course, was pitched head foremost, off his horse upon the ground, the animal being at the time under full speed. He was picked up in a state of utter insensibility, and a large tumor was discovered just above the left eyebrow, with a well-marked central depression. Although convinced that the bone beneath was sound, I was induced, at the earnest entreaty of Dr. Knight and Dr. Wakefield, to cut through the part, but found no fracture. The lad never recovered his consciousness, and died in a few days after the receipt of the injury. An extensive fracture existed at the base of the skull.

A lad, eleven years old, a patient of Dr. O'Reilly, was thrown off his horse, striking his head violently against a fence. On the right side of the head, just in front of the temple, was a severe contusion, feeling very soft, and readily permitting the finger to sink down into it at the centre, thus imparting the sensation of a badly depressed fracture. The lad had been somewhat stunned, but soon regained his consciousness. Being in doubt whether the appearance was real or not, I made a small incision across the swelling, down to the bone, but found no fracture. Recovery occurred without an unpleasant symptom.

To the above cases might be added several others, but, as they are sufficiently typical of the occurrence in question, this will be unnecessary. What increases the embarrassment in such a condition is the fact that the deceptive appearance of the scalp is often associated with symptoms of compression of the brain, inducing the idea that the cerebral affection might be caused by depression of the skull.

Doubt may sometimes be thrown upon the diagnosis by malformation of the skull. A man, thirty-two years of age, came under my observation, on account of a wound upon the posterior part of the head, received a week previously by being struck with a piece of iron. He was stunned by the blow, and for several days he was hardly able to walk across the room. The wound, which was about two inches and a half in length, extended down to the bone, and was situated over a ridge just behind the lambdoidal suture. On passing my finger around the wound, I found, immediately in front of it, a broad, deep hollow, reaching forwards towards the sagittal suture, and looking very much like a depression from a fracture. Upon inquiry, however, I

ascertained it had always existed there, having been the result of malformation. The patient, on his entrance, had violent headache, along with considerable fever, for which he was bled and purged, and from the effects of which he soon recovered. Had he labored under compression of the brain, the deceptive appearance caused by this state of the bone might have induced an incautious surgeon to apply the trephine.

It is hardly probable that any surgeon, at the present day, would mistake a suture of the skull for a fracture. Such an error is said to have been committed by Hippocrates, who actually applied the trephine for the relief of his patient. An accident like this could only be excused in a case where symptoms of compression are superadded to the depressed appearance of a bone from malformation, the suture running across its surface, and the scalp being more or less contused from the injury.

12. *Intra-uterine Fractures.*—Fractures of the foetal skull during intra-uterine life may arise under two very opposite circumstances; first, from violence inflicted by a fall or blow upon the abdomen of the mother, and, secondly, from injury sustained during the passage of the child's head in parturition. That the former occurrence is possible is shown by the fact that various bones of the skeleton have been known to be broken by violence applied to the foetus through the abdomen of the mother. I am myself cognizant of two cases of fracture of the clavicle that took place in this way, and many examples of a similar nature have been recorded by different observers. It requires no argument, therefore, to prove the possibility of such an accident; what may happen to one bone may, under like circumstances, happen to another.

The second mode in which fracture is produced is by far the more common of the two, and, what is remarkable, the accident may take place independently of any distortion of the pelvis or the application of instruments. In some of the recorded cases, in fact, the labor was neither severe nor tedious. In general, however, the occurrence will be most likely to happen when the pelvis is unnaturally narrow, or when there is a disproportion in its size and in that of the skull, or where, in consequence of the violence of the uterine contractions, the head is jammed firmly into the pelvis. Under such circumstances, it is easy to conceive of the possibility of such an accident. Indeed, it is only surprising when we reflect upon such cases that they are not of much greater frequency. Sometimes the accident has happened without any assignable cause; and occasionally it is justly attributable to the interposition of one of the arms between the head of the child and the bony wall of the pelvis.

The fracture is seldom extensive. In general, it presents itself in the form of one or more fissures, from six to eighteen lines in length, without any concomitant displacement. Sometimes there is marked depression, and a case has occasionally been witnessed in which a spicule of bone could be distinctly felt under the integument. The occurrence is nearly always, if not invariably, associated with a bloody tumor of the scalp, caused by the rupture of the vessels of the part in consequence of the excessive pressure exerted upon the head in parturition. Owing to this circumstance, it is generally impossible to distinguish the existence of the lesion, unless it is accompanied by displacement or unusual mobility of the fragments, an occurrence of great rarity. In a case of intra-uterine fracture observed by Flugel, the expulsion of the head was preceded by "a loud crack," and the dissection disclosed the existence of two fractures, one of which was an inch and a third in length. The pains were rapid and forcible, and the labor terminated in seven hours without any aid, the case being one of face presentation.

The intra-uterine fracture generally involves the parietal bone, or the parietal and frontal. The occipital rarely suffers, and there are very few cases in which the temporal bone is implicated. The subjects of these lesions are usually still-born, or, if they survive their birth, they perish within a short time after from the injury inflicted upon the brain and its membranes, or from the immediate effects of extravasation of blood.

These fractures were formerly ascribed to violence wilfully inflicted by the mother for the purpose of destroying her offspring. The error of this opinion, however, was gradually corrected by obstetric practitioners; and it is needless to say how important is the distinction, especially in a medico-legal point of view. Fractures of this kind, caused by injury transmitted through the abdomen of the mother, have occasionally been found in an advanced stage of repair. In a case recorded by Pro-

fessor Montgomery, of Dublin, a depression, capable of containing an almond in its shell, existed in the left temporal bone, but disappeared spontaneously within a few months after birth.

The treatment of these cases consists in the administration of minute doses of calomel, as the third or fourth of a grain, three times daily, and in the application of a solution of hydrochlorate of ammonia, in the proportion of one drachm of the salt to the pint of water, with the addition of two ounces of vinegar. If marked displacement exists, the fragments, as a preliminary step, are carefully moulded into shape by gentle pressure.

SECT. V.—GUNSHOT INJURIES OF THE HEAD.

Gunshot injuries of the head constitute an important class of lesions, often difficult of diagnosis, and liable, even when comparatively slight, to be followed by the most serious consequences. They may be limited exclusively to the scalp, merely grazing, bruising, or dividing its substance; or they may involve the cranial bones; or, finally, they may embrace all these structures, along with the brain and its envelops.

The frequency of these injuries, as compared with gunshot wounds of other portions of the body, may be stated to be about 8 per cent., or 1 in every 12, the computation being based upon 151,394 cases collected by Dr. S. W. Gross, in 11,939 of which the head was affected. Of this number 72.8 per cent. were confined to the scalp, of which only 3.5 per cent. were fatal, while in 27.2 per cent. the skull and its contents were involved, of which not less than 66.8 per cent. perished.

The number of cases of gunshot injuries of the head, reported during the late war, was 5406, of which 1104 were attended with perforating, penetrating, and depressed fractures. Of 604 cases, of which the result is known, 405 died, and 199 recovered. In 394 of the cases the lesion was, apparently, limited to the scalp, in the form of wounds and contusions, and of these 103 terminated fatally, the cause of death in most of them having been due, as Dr. Otis very justly supposes, to some undetected affection of the skull, brain, meninges, or other structures, as concussion, compression, inflammation, necrosis, pyemia, or abscesses of the lungs and liver, consequent upon phlebitis of the diploë.

1. *Gunshot Injuries of the Scalp.*—These lesions derive their chief importance from their proximity to the brain and their consequent liability to give rise to encephalo-meningitis. Erysipelas is also a common occurrence, and occasionally they are followed by jaundice, with or without abscess of the liver. When the missile penetrates the pericranium, or contuses the skull, the accident may cause suppuration and slight exfoliation of the outer table of the bones. The prognosis after such injuries should, therefore, always be very guarded, the more so when it is recollected that they are not unfrequently accompanied with serious mischief to the brain and its envelops.

The modern military surgeon meets no longer with any of those curious cases of the circuitous route pursued by balls in gunshot injuries of the scalp, so much spoken of by European writers in the early part of the present century, during the reign of the round missile. The conical bullet performs its work much more neatly, rarely glancing, or deviating from the straight line.

The treatment of these lesions is similar to that of gunshot injuries in general. If the ball has lodged, immediate extraction is effected, any foreign matter that may have entered along with it being removed at the same time. Such wounds, which cannot be watched with too much solicitude, often require dilatation and counter-opening, to afford vent to effused fluids.

2. *Gunshot Injuries of the Skull.*—These injuries may be divided into three classes: 1st, contusions and fractures of the bones without depression; 2dly, fractures with depression; 3dly, fractures with penetration of the brain and its envelops.

a. *Contusions and Fractures without Depression.*—Grave injury is often inflicted upon the skull by the blow of a ball or shell, the osseous tissues being violently bruised and shaken, but not broken. Such a lesion is generally fraught with danger from the fact that it is nearly always attended with serious disorder of the brain, as concussion, contusion, or laceration, eventuating, if the case is at all severe, or improperly managed, in destructive inflammation. The danger here, however, is not merely in the first instance; the patient may happily survive the primary effects

of the accident, but perish from the secondary, death happening, perhaps, weeks, if not months, after the receipt of the blow. Even under the most favorable circumstances, recovery will be tedious and troublesome, if for no other reason than the fact that abscesses under the scalp will be apt to be repeated, with more or less extensive exfoliation of the contused bones.

Contusions of the skull are often attended with copious extravasation of blood, especially when there has been a rupture of the middle meningeal artery. In such an event, there will necessarily be evidence of compression of the brain, sometimes speedily terminating in death.

Sometimes a ball or shell, in traversing the skull, scoops out a portion of its substance, leaving thus a pretty deep furrow, groove, or gutter, perhaps several inches in length; or the missile strikes the bone, and breaks it, not unlikely at several points, causing a fissured, stellated, or even a comminuted fracture, without depression. Occasionally, although rarely, a shell carries away bodily a considerable portion of the skull-cap, along with the corresponding portion of scalp. The danger of all such injuries is too apparent to require comment. When the diploë has been extensively exposed, the patient will run great risk of perishing from pyemia and erysipelas, owing to the liability of the pus to find its way into the blood, and to lead to the development of emboli and metastatic abscesses in the lungs, liver, and other structures.

The treatment must be strictly antiphlogistic, blood being taken freely by leeches, or even by the lancet, if the patient is at all plethoric, and the danger from cerebral involvement imminent; the bowels are thoroughly moved by drastic cathartics; the heart's action is controlled by the antimonial and saline mixture, with the addition of a suitable quantity of tincture of *veratrum viride*; and the head, shaved and elevated, is kept constantly covered with pounded ice, or some refrigerant lotion. If the case is obstinate, mercury is employed, in doses of two to three grains thrice a day, with a view to rapid and decided pyalism.

3. Fractures with Depression.—Gunshot fractures of the skull with depression of the bone are among the most common and fatal injuries on the field of battle. The bone may be broken without a wound in the scalp, the latter being, perhaps, merely somewhat contused, as when the blow is inflicted by a shell or a partially spent round shot; but, in general, there is also an opening in the soft parts, the case thus constituting one of compound fracture. The bone, moreover, may be comminuted, or shattered into numerous fragments. The skull is sometimes frightfully broken, and yet the scalp remains literally intact. A case of this kind, referred to by Dr. Macleod, occurred at the battle of the Alma. A round shot, passing in ricochet, struck the scale from an officer's shoulder, and merely grazed his head as it ascended. The result was instant death. The skull was so completely mashed that the fragments rattled under the scalp like so many marbles in a bag. The brain was not examined.

The amount of depression in this form of fracture is variable, depending upon the size and force of the missile and the brittleness and thickness of the skull. Occasionally it is extremely slight, but examples occur in which it is of frightful extent, involving the greater portion of the posterior vault of the skull, the vertex, or the frontal bone, as represented in fig. 86.

In rare cases the fracture is limited to the outer or inner table; probably more frequently to the latter than the former. The possibility of a fracture of the inner table was at one time universally rejected, but that it may take place has been satisfactorily shown by military surgeons, ancient as well as modern. Among the former may be mentioned Paré, Tulpus, Ravaton, Delamotte, and Borelius, and among the latter S. Cooper and Huguier. The lesion manifests itself in various forms. Thus, it

may occur as a mere crack or fissure, as in a case met with in the Crimean war, in which the ball denuded the bone but left no trace of fracture. The man died on the thirteenth day from the pressure of a large clot of blood and extensive inflammation, when a fissure, confined to the inner table, was found running in the line of

Fig. 86.



Extensive Shell Fracture of the Skull.

the track of the projectile. Dr. Demmé observed four cases in the Italian campaign in 1859, in which the inner table was broken without any fracture of the outer one.

Fig. 87.



Fracture with Complete Detachment of the Inner Table of the Frontal Bone.

In one of these cases a piece two inches square had become completely detached. During our late war eight cases of a similar kind occurred, the specimens of all being now in the Army Medical Museum at Washington. One of the most remarkable of these is represented in fig. 87.

The case of Ravaton is so circumstantially detailed that it deserves to be reproduced here, on account of its great practical interest. When the man was first seen by this great surgeon, six weeks had already elapsed since the receipt of the injury. The bone, on being exposed by an incision, was found to be of a blackish color, but without any appearance of fracture; the pericranium was detached, hard, and thickened, and the inner table was not only extensively broken but depressed to the depth of nearly three-quarters of an inch, the osseous pouch formed by its separation being filled with clotted blood and serosity. Death occurred some hours after the operation. The vessels of the membranes of the brain were deeply congested, and the whole of the longitudinal sinus was in a state of

suppuration. The principal symptoms, setting in suddenly within less than forty-eight hours prior to the operation, were profound coma, convulsions, frequent pulse, and copious sweats.

The existence of such a fracture must always necessarily be involved in great uncertainty, especially when, as in the instance of Ravaton, there is simply a contused state of the scalp without any immediate brain symptoms. Even when the bone is exposed, and exhibits every appearance of being dead, it affords no positive evidence that the inner table is broken and depressed, inasmuch as such a condition is invariably present when a portion of the cranium has been crushed in consequence of injury to the periosteum, the detachment of the dura mater, or the formation of an abscess within the skull.

Punctured gunshot fractures are not uncommon, the missile forcing in the outer table, in a concentrated form, against the internal, which, in consequence, is more or less extensively broken and depressed, if not completely detached. The danger of such an accident, of which the annexed sketches, figs. 88 and 89, copied from the

Fig. 88.



External View of Punctured Fracture of Frontal Bone.

Fig. 89.



Internal View of Same Specimen, the Bone being Extensively Splintered and Slightly Depressed.

Surgeon General's Report, are graphic illustrations, is always imminent, inasmuch as it is sure, if prompt relief be not afforded, to cause destructive inflammation.

There are certain rules which, in the *treatment* of fractures of the skull with depression, are applicable to all cases of the injury, whatever may be its extent. These are, first, to remove foreign matter, so as to place the parts in the best condition for satisfactory reunion, and, secondly, to guard against the supervention of undue inflammation. The disposition of the missile varies. It seldom lodges, but rebounds, and is lost. When it is arrested, it will generally be found to be much flattened, very irregular, and either imbedded in the bone, or intercepted in a crevice of the fracture. Sometimes it is cut in two, one portion being lost, while the other either lies under the scalp or has entered the brain. However this may

be, it must, if found, be promptly extracted, along with any fragments of bone that may be very loose, or completely detached. In regard to the depressed bone itself, it should undoubtedly be elevated, if this can be done without inflicting serious injury upon the brain and its envelops. To leave it in its unnatural position would be productive only of future mischief. In making this remark, I certainly do not wish to be understood as advocating interference in every case of depressed fracture. When the accident is very slight, and, especially, when it is unaccompanied by a wound of the scalp, the best plan is to let the parts alone, the surgeon restricting himself to the employment of such means as may tend to favor rapid and permanent cerebral accommodation. But there are cases in which the propriety of trephining is so self-evident as not to admit of the slightest hesitation. Such cases fall under the same rules as similar injuries in civil practice. If the depressed bone, perhaps terribly shattered, and, to a considerable extent, even thrust into the brain, is not promptly removed, it must either cause fatal inflammation, or, if recovery should occur, eventually lead to epilepsy and other distressing affections, rendering life hardly worth the possession.

There seems to be a growing disposition on the part of practitioners to eschew the use of the trephine nearly, if not entirely, in depressed fractures of the skull. Thus, Dr. Stromeyer, surgeon-in-chief in the Schleswig-Holstein war, pointedly condemns the operation in every case, on the ground that, independently of the mischief inflicted upon the tissues during its performance, the admission of air to the contused portion of the brain and its membranes greatly augments the danger of inflammation. Of 41 cases of gunshot fractures of the skull with depression, reported by him, 7 died, and 34 recovered. Among the latter was one which had been trephined, and this was the only instance of the kind throughout the war which gave a favorable issue.

Observations made in the Crimean war strongly corroborate the views of Dr. Stromeyer. The English surgeons applied the saw successfully only in four cases, and in those not on account of rifle-ball wounds, during the entire campaign; and the operation does not seem to have been any more favorable in the French army, Dr. Serive asserting that it was for the most part fatal. Of ten cases trephined by Pirogoff only three recovered; and of a similar number in the hands of other surgeons the issue was equally unpropitious. During our late war the trephine was employed in both branches of the service 111 times, with 62 deaths and 49 recoveries. Dr. Macleod concludes, from the result of his experience, that interference is only admissible when the bone is very deeply depressed on the brain, and the patient is comatose, with stertorous breathing, a slow pulse, and a dilated pupil. In all other cases, in which these phenomena are not very decidedly marked, or where they do not continue for any considerable length of time, trephining should, he thinks, be avoided.

The above views, although emanating from men of large experience, should, I think, be received with great caution when applied as rules of practice. Every surgeon knows that there are certain lesions of the skull which must necessarily be fatal under any mode of treatment, however judiciously conducted, and the very fact that the use of the trephine is required, is of itself an evidence that the case will be one of doubtful issue, not so much in consequence of the injury inflicted upon the parts during the operation, or, as Larrey and Stromeyer suppose, of the admission of air, but of the intrinsic mischief done to the brain and its membranes by the primary blow. As a proof of the great mortality of such lesions, it may be stated that, in the Crimean war, they invariably ended fatally whenever they were at all severe. Of 76 cases of depressed fractures unattended with penetration or perforation, 55 perished, 12 were invalided, and 9 only were discharged as fit for duty. In the 21 who survived, the amount of depression was very slight, and all these, excepting one, recovered without a bad symptom. Of 86 cases, in which the skull was perforated, not one was saved.

That the great mortality after trephining is due to the extent of the primary injury and its effects upon the brain and its membranes, and not to the operation itself, has been clearly and satisfactorily elucidated by Dr. S. W. Gross in a paper published in the *American Journal of the Medical Sciences* for April, 1867. Thus, of 160 cases of trephining in army practice, 97, or 60.62 per cent., were fatal; while of 573 serious gunshot injuries of the skull treated by expectancy, 426, or 74.34 per cent., perished. Of 126 cases in which fragments of bone or various foreign substances were removed with the elevator, forceps, or, less frequently, with Hey's saw,

56 recovered, and 70, or 55.55 per cent., died. A comparison of these results shows a ratio of recoveries after trephining alone of 39.38 per cent., after the elevator, forceps, and saw of 44.45 per cent., after all operative measures combined of 41.61 per cent., and after conservative treatment of only 25.66 per cent. Since the cures after surgical interference and expectancy are in favor of the former by 15.95 per cent., it follows that the mortality from gunshot injuries of the skull must be referred to cerebral disorders and not to the operations practised for their relief. Of 252 cases of trephining, derived from private and hospital practice, European and American, analyzed by Dr. Gross, 133, or 52.77 per cent., perished, the mortality being less than that of army practice by 7.85 per cent.

Moreover, it must be remembered that there is a great difference between gunshot lesions of the skull as inflicted with the conical and the round ball, the former making, as a general rule, an incomparably worse wound than the latter. In former times, men injured with the round ball often made excellent recoveries, with hardly any treatment at all, or perhaps even after the most severe exposure and fatigue, evidently because, although the cranium was apparently badly hurt, the brain and its membranes had sustained little or no injury. Thus, after the battle of Talavera, of fourteen men with wounds in the head, involving the skull, not one died, notwithstanding they were compelled to march for sixteen consecutive days under the influence of a burning sun, with no other treatment than simple water-dressing. In several of these cases both tables of the skull were broken, and in two fracture of the frontal bone coexisted with destruction of the globe of one eye. Now, no one will presume to assert that these men would have fared so well, if they had been wounded with the sharp, heavy Minié ball, instead of the old round ball, used in the Peninsular war.

When the internal table alone is depressed or splintered, trephining affords the only chance of relief, as is exemplified in the celebrated case treated by Mr. Samuel Cooper, in which, at the battle of Waterloo, a large splinter was driven more than an inch into the brain, the patient on its extraction instantly recovering his senses and the power of voluntary motion. The part of the skull to which the instrument was applied did not indicate any depression, and was only selected because the scalp showed that there the injury had been inflicted, the existence of extravasated blood having been suspected instead of a fracture of the inner table of the skull.

Finally, in compression of the brain from blood or pus, consequent upon gunshot injuries, the same rules of practice are to be pursued as in ordinary cases. The great difficulty here will be, not in performing the operation, but in knowing when it is necessary. In general, the formation of matter, under such circumstances, does not occur under several weeks.

γ. *Fractures with Penetration of the Brain.*—These injuries are nearly always promptly fatal, the patient dying either on the spot from shock and hemorrhage, or, at all events, within the first eight days, from the effects of inflammation. The danger in these cases is not from the ball alone, although this is generally very great, but also from the presence of pieces of bone, hair, and other extraneous matter which are forced in with it, and which are often much more destructive than the missile itself, contusing, tearing and pulpifying the cerebral tissues in the most frightful manner. A ball, lodged in the brain, is sometimes encysted, and may thus become a comparatively harmless tenant, the functions of the mind and body being performed with their accustomed vigor; in general, however, it acts as an irritant, even when it is thus isolated, exciting inflammation, which is certain to be followed by abscess and death. Bone and other foreign matter are never encysted; the lymph effused around them is incapable of organization, and the consequence is that they soon produce fatal disturbance.

Although gunshot wounds of the skull and brain nearly always prove fatal, yet a remarkable exception occasionally occurs, the patient getting well, as it were, despite the injury, and in defiance of all the laws of prognosis. This was happily exemplified in the case of a youth, aged eighteen, the particulars of which have been kindly communicated to me by Professor May, of Washington. The ball, an ounce one, entered the upper and back part of the skull, making an opening capable of receiving the index finger, and penetrating the brain, as was proved by the fact that some of it had escaped at the wound. Where the ball lodged could not be ascertained. Rapid and complete recovery followed without a solitary untoward symptom. An instance of a parallel character has been furnished me by Dr. William Lough, of

Missouri, the patient being a lady eighteen years of age, who recovered so completely that she afterwards married and bore children. The ball, a small round one, entered the left temporal bone, losing itself in the brain, as was proved by the fact that some of its substance exuded at the external opening and that a probe was readily passed to the depth of an inch and a half.

A case reported by Dr. W. W. Keen and Dr. William Thomson, in the *Philadelphia Photographic Review of Medicine and Surgery* for 1871, admirably illustrates how recovery may occasionally occur after an injury of this kind, even when apparently of the most desperate character. The wound, inflicted at the battle of Antietam, occupied the posterior and middle part of the skull, the openings of entrance and exit being three inches apart. The cavity left by the latter was two by two and a half inches in diameter, and twelve lines in depth, involving the hemisphere of the brain to a fearful extent. The unconsciousness and paralysis, consequent upon the injury, lasted several months; and the large fungus which formed during the progress of the cure, was shaved off not less than five or six times. Notwithstanding this immense amount of injury, recovery gradually ensued, with only slight impairment of sight and memory. When recumbent, the hollow in the head, as I have myself observed, is gradually effaced, and replaced by a rounded protuberance. A similar effect is produced by coughing. The pulsations of the brain are barely perceptible.

An instance of gunshot wound of the head, observed by Dr. Benjamin Howard, shows upon what a very trivial circumstance the diagnosis of a case sometimes hinges. The missile had struck the left temple, and, passing underneath the scalp, entered the frontal bone a little to the right of the middle line, causing a kind of trap-door fracture, with a triangular depression, and an aperture so small as not to admit a common probe. Believing, from the character of the symptoms, and the presence of a single hair in the fracture, that the ball, a fragment of which had previously been removed from the scalp, had penetrated the brain, he applied the trephine a fortnight after the accident, and thus succeeded in finding it, although it was buried in the cerebrum at a depth of two inches. The softened and discolored cerebral substance being scraped away, the parts were united in the usual manner, and the case treated upon rigidly antiphlogistic principles, the man, who was nineteen years of age, making an excellent recovery.

Baron Larrey has recorded a case in which a ball, entering the forehead, lodged in the posterior part of the brain, from which he extracted it by trephining the occiput, the missile falling upon the floor.

An officer wounded at the battle of Wagram died many years after, at an advanced age, when the ball was found in the left lobe of the cerebellum. His genital organs retained their vigor for a long time. A case has been recorded in which a ball lay in the fourth ventricle for forty-one days before it caused death. All the faculties, muscular, organic, and intellectual, were perfect to the last.

A remarkable case of shot wound of the frontal bone has been recorded by Dr. J. O. Harris, of Illinois, in a child, seven years of age. The shot, sixteen in number, made, as they entered the brain, a solitary, ragged opening in the forehead, nearly one inch in diameter. As the child was comatose, he contented himself with removing some loose splinters, and applying simple dressings. No serious symptoms, however, afterwards arose, and, in three weeks from the time of the accident, the little patient was perfectly well, with the exception of the retention of a few pieces of dead bone.

The treatment of these accidents resolves itself into the removal of foreign matter, the elevation of depressed bone, and an effort to sustain the brain in its attempts at repair. The finger is, of course, the best probe, but all officious interference is to be avoided, inasmuch as it is far better to let the missile and even detached pieces of bone remain where they are than to search for them at the risk of severe additional injury. A counter-opening with the trephine, with a view of facilitating the extraction of the ball, is hardly to be thought of in any case, although two instances have been recorded, one by Larrey and the other by Charles Bell, in which such a procedure was followed by the most happy result.

The antiphlogistic measures must be strictly gauged by the exigencies of each particular case; depletion must not be carried to excess; if the shock and loss of blood have been great, stimulants and even anodynes may be required from the start, to support the system and quiet the heart's action. Fungus, so apt to arise during the progress of the treatment, should be repressed in the usual manner.

Foreign bodies, of considerable weight and bulk, occasionally remain in the substance of the brain for a great length of time, without provoking serious disease, the patient, perhaps, in the mean while enjoying very good health, both of mind and body. Langlet met with an instance in which a large ball was retained in this organ for eighteen months, before it excited fatal inflammation, and a still more remarkable one has been recorded by Anel. In this case, the man remained well for many years, the ball, after death, being found lying upon the pineal gland. Dr. O'Callaghan attended an officer who lived for seven years with the breech of a fowling-piece, weighing three ounces, in the forehead; and a number of similar examples have been recorded by other observers.

But, although a foreign substance may thus occasionally remain for a time as a harmless tenant in the brain, it is sure, sooner or later, to excite inflammation, eventuating in destructive softening and suppuration. In the remarkable case of Anel, above referred to, the wounded man lived for many years without apparently any inconvenience from the ball, but at last died very suddenly, while playing cards. The missile was deeply lodged in the brain, surrounded by recently effused blood.

Gunshot Injuries of the Orbital Plate of the Frontal Bone.—Experience has shown that a ball, entering the orbit, and passing directly backwards and upwards, generally destroys life by the violence which it inflicts upon the brain and its envelops, the patient dying either on the spot from shock and hemorrhage, or within a few days after the accident from inflammation. If, on the contrary, it pursues a downward course, the brain may entirely escape, or suffer merely in a slight degree.

The eye is often seriously implicated in gunshot injuries in this situation; in some instances it is totally annihilated, while in others it is so severely wounded as to be destroyed by the resulting inflammation. Occasionally the globe of the organ escapes, but the optic nerve is cut off, the lesion being followed by immediate and permanent blindness.

It is well known that the orbital plate may be severely shattered, and yet, if the case be properly treated, the pieces may ultimately perfectly reunite; for such is the abundant supply of vessels and nerves of the soft parts of the face and eye that they impart to this portion of the skeleton a much greater conservative power than is possessed by the osseous system in general.

A ball sometimes passes across the skull from one temple to the other, without inflicting any serious injury upon the brain or other soft parts, the patient ultimately making a good recovery. Such an occurrence, however, is much less common now than formerly, during the use of the round ball. After the battle of Waterloo a number of cases of this kind were treated successfully by the British surgeons.

Gunshot Fractures of the Mastoid Process.—Ordinary injury, as a blow or fall, does not seem to be capable of fracturing this process, but such an effect may readily be

produced by the passage of a bullet, and the late war furnished a considerable number of such cases. The accident may be quite simple, merely exposing the mastoid cells, as in fig. 90, or it may be complicated with serious lesion of the middle ear, eventuating in violent inflammation and in loss of hearing. When the missile is very rough, or when the bone is much shattered, erysipelas is very liable to occur, troublesome abscesses and sinuses form, and a long time generally elapses before a complete cure is accomplished.

A very curious case of gunshot fracture of this process, attended with complete separation of the apex from its base, has been reported by Dupuytren. The ball entered anteriorly, and, perforating the right concha, issued near the outer border of the splenius. The apex of the bone was drawn downwards and forwards by the sterno-mastoid muscle, the amount of displacement being increased or diminished as the



Gunshot Fracture of the Mastoid Process.

head was moved to the left or right. In order to counteract this tendency of the muscle, the head was confined, by means of an appropriate apparatus, to the chest

in such a manner as to keep the chin permanently inclined towards the left side. The muscle being thus relaxed, the fragment retained its proper position, and gradually united by ossific matter.

When the bullet is firmly imbedded in the bone, the best plan is to remove it at once with the trephine. If allowed to remain, it would only be productive of mischief. A similar procedure should be adopted when there is imprisoned necrosed bone.

SECT. VI.—SWORD AND ARROW INJURIES OF THE HEAD.

Fractures of the skull inflicted by the sword, sabre, or Indian arrow, are generally of a very grave character, usually proving fatal, either from shock, hemorrhage, or inflammation. A sharp arrow, as I am informed by Dr. T. C. Henry, of the Army, will cut a hole into the skull, owing to the great force and velocity with which it is propelled, without apparently any fracture whatever, producing a kind of incised wound, which, however, is very liable to be followed by death. A portion of the outer table of the skull, or even of its entire thickness, is sometimes sliced off by a sabre or sword, hanging, perhaps, merely by a narrow flap of scalp, as in fig. 91. When this is the case, the parts should immediately be replaced, and secured by suture, in the hope of their speedy reunion.

Wounds of this kind, apparently of the most desperate character, are sometimes happily recovered from. A case related by Ambrose Paré admirably illustrates the truth of this remark. "A party," he says, "had gone out to attack a church where the peasants of the country had fortified themselves, hoping to get some booty of provisions; but they came back very soundly beaten, and one, especially, a captain-lieutenant of the company of the Duke de Rohan, returned with seven gashes on his head, the least of which penetrated through both tables of the skull, besides four sabre wounds in the arm, and one across the shoulder, which divided one-half of the shoulder-blade. When he was brought to the quarters, his master, the duke, judged him to be so desperately wounded that he absolutely proposed, as they were to march by daylight, to dig a ditch for him, and throw him into it, saying that it was as well that the peasants should finish him. But being moved with pity, I told him," says Paré, "that the captain might get cured. Many gentlemen of the company joined with me in begging that he might be allowed to go along with the baggage, since I was willing to dress and cure him. This was accordingly granted. I dressed him, and put him into a small, well-covered bed, in a cart drawn by one horse. I was at once physician, surgeon, apothecary, and cook to him, and, thank God, I did cure him to the admiration of all the troops, and out of the first booty the men-at-arms gave me a crown apiece, and the archers half a crown each."

Fig. 91.



Sabre Cut of Parietal Bones.

SECT. VII.—WOUNDS OF THE BRAIN AND ITS MEMBRANES.

Wounds of the brain and its membranes may be produced in various ways, or by whatever is capable of causing fracture of the skull. From the character of the weapon by which they are inflicted, they may be incised, punctured, lacerated, contused, or gunshot. They may occur without fracture, as when they are the result of contre-coup, but the most severe varieties of the injury are always associated with fracture and wound or laceration of the meninges of the organ. As stated under the head of concussion, this lesion is not unfrequently complicated with laceration of the cerebral substance, exhibiting itself in the form of a rent or fissure, often several inches in length. Such an occurrence is by no means uncommon at the base of the brain from fracture by contre-coup, as happens when a person falls from a great height and alights upon the top of the head. A severe wound of the brain is sometimes caused by depressed bone, or by a spicule of bone driven down into the substance of the organ. Punctured wounds in the adult are generally confined to the anterior lobes of the brain, and are usually inflicted with narrow, sharp-pointed

instruments, such as a fork, pen-knife, stick of wood, dirk, bayonet, and the like, thrust across the orbital plate of the frontal bone. Children, before the completion of ossification, may be injured in a similar manner through any portion of the skull. A case has been communicated to me of a punctured fracture of the skull, by a long nail penetrating deeply into the brain, in a lad six years old. The child, in falling from a considerable height, struck the top of his head against the nail, which was thus driven nearly two inches into the left hemisphere. In another case, which I saw along with Dr. Rogers, a little boy fell, head foremost, upon the point of an iron fence rail, receiving a frightful wound of the brain, and literally impaling himself. The cranial bones were extensively comminuted, and a large quantity of brain escaped during the removal of the loose fragments. Convulsions soon followed, and recurred, with more or less frequency and violence, up to the time of death, eighteen hours after the accident. A badly punctured wound is sometimes inflicted upon the skull of a child by the spur of an infuriated cock. The brain has been known to be traversed from one extremity to the other by a ball, bayonet, dirk, sword, or other weapon. Occasionally, again, the vulnerating body is retained in the organ. Thus, a ball, the butt-end of a pistol, pieces of iron, fragments of bone, and various other substances, have been found within the skull, in contact with the surface of the brain, or lodged more or less deeply in the cerebral substance. What is remarkable, in such cases, is that the extraneous matter does not always speedily cause death. Instances, as stated in a previous page, are upon record of balls having become encysted in the brain, and afterwards remaining comparatively harmless. The usual tendency, however, of such bodies is to excite fatal inflammation.

But the most formidable wounds of the brain are generally those which accompany compound fractures of the skull and extensive laceration of the meninges. They are usually of a lacerated and contused nature, are apt to be followed by copious hemorrhage, and are frequently attended with pulpification and disintegration of the cerebral tissues, which sometimes escape in large quantity.

The *symptoms* and effects of wounds of the brain vary according to the extent of the lesion, and also according to the particular parts implicated. When the lesion is comparatively small, and the cerebral substance is not too much mashed or contused, recovery is altogether within the bounds of possibility, and may, under judicious management, take place even readily. The great danger to be apprehended, in all cases, is encephalitis, with the formation of fungus, or protrusion of a portion of the brain. The mind is not necessarily affected, and the patient often recovers without any untoward symptoms. When the accident is more severe, the danger will, of course, be greater; but even here it is wonderful what little disturbance sometimes follows in cases apparently the most desperate. Occasionally large quantities of cerebral substance are lost, and yet the patient makes a most excellent recovery, his intellect being not only not weakened, but, perhaps, improved by the occurrence. Such cases are, of course, uncommon, and are chiefly interesting as serving to show the extraordinary resources of the system in surmounting the effects of some of the most frightful accidents that can possibly befall it. In some of these cases there was even an absence of serious symptoms. Paroisse has given an account of twenty-two French soldiers, who, notwithstanding their vertices had been sliced off by sabre-strokes, along with more or less brain, were so free from suffering that they performed a journey of thirty leagues, one-half of the distance on foot, twelve finally recovering.

When the wound involves the base of the brain, or the superior portion of the spinal cord, life may be instantly destroyed by the stoppage of respiration. The intellectual faculties are also more deeply affected, if not completely annihilated, and ultimate recovery is doubtful in any case, however simple. If the patient is so fortunate as to escape with his life, he will afterwards suffer from loss of bodily and mental power; the mind will be permanently crippled, some of the special senses will be weakened, if not abolished, and the limbs will be affected with paralysis and contraction, followed sometimes by the most disgusting deformity. Epilepsy is also of frequent occurrence. Wounds of the cerebellum are often followed by priapism and other evidences of inordinate sexual excitement.

The *prognosis* of wounds of the brain and its membranes is altogether too variable to admit of general specification. While in some cases, indeed in a great many, the slightest injury causes death, in others, attended, perhaps, with excessive shock, and the loss of a large quantity of blood and cerebral matter, the most prompt

and satisfactory recovery occurs. Thus, in a case treated by my colleague, Professor Ellerslie Wallace, the fracture, inflicted by a circular saw, was four inches and a quarter in length by one-sixth of an inch in width, extending horizontally across the skull, along the coronal suture, wounding the brain, and dividing the longitudinal sinus; and yet the patient, a girl ten years of age, rapidly recovered without one untoward symptom. Another case, equally frightful, followed by an excellent cure, was reported in 1869, by Dr. A. C. Fulsom.

A still more extraordinary instance happened in 1848, in the practice of Dr. J. W. Harlow, of Vermont; a case so unique that, if it were not well attested, its occurrence could hardly have been supposed to be possible. The accident took place while the man, who was twenty-eight years of age, was engaged in blasting rock, by the propulsion of a tamping iron, three feet seven inches in length by one inch and a quarter in diameter, and weighing upwards of thirteen pounds. The iron entered by its narrow extremity, near the angle of the lower jaw, on the left side, passing obliquely upwards behind and below the zygomatic arch, traversing the skull, the anterior lobe of the cerebrum, and the longitudinal sinus, and fracturing, as was supposed, the malar, sphenoid, temporal, and frontal bones, at the latter of which it emerged, just in advance of the coronal suture. Notwithstanding this horrible mutilation, the man made an excellent recovery as it respected his bodily health, but so completely changed in his disposition that he was ever after fitful, irreligious, vascillating, and impatient of restraint. He remained in this condition for twelve years and a half from the time of the accident, when he was seized with violent epileptic convulsions, in one of which he expired. No post-mortem examination was made.

Wounds of the meninges are always very grave accidents, often as surely fatal as wounds of the brain itself. Even a mere separation of the dura mater from the inner surface of the skull is usually a most dangerous occurrence, independently of any fracture of the bone or extravasation of blood. Such an accident, even when the detachment is comparatively insignificant, is almost invariably followed by subcranial abscess, the necrosis of the corresponding portion of the bone, and inflammation of the different membranes. The dura mater, which is more immediately concerned in the injury, is softened, thickened, injected, discolored, and incrustated with lymph. When the morbid action runs uncommonly high, sloughing will be apt to arise, followed by fungus of the brain, and a discharge of thin, foul, offensive matter.

The membranes of the brain generally suffer more or less severely in comminuted fractures, from the ends of some of the fragments being forcibly driven into their substance, if not also into that of the brain. If speedy removal be not effected, they most invariably cause violent inflammation in all these structures, attended with unnatural vascularity, deposits of lymph, effusion of serum, and, if the case last sufficiently long, the formation of pus. The subarachnoid tissue nearly always participates in the disease, as is shown by the turgid condition of its vessels and the presence of a greenish, sero-plastic material, which is often poured out in large quantity. Such lesions are necessarily always speedily fatal, no matter what plan of treatment may be adopted for their relief.

The *treatment* of wounds of the brain and its envelops must be conducted upon the most rigid antiphlogistic principles; great care, however, must be taken not to carry this plan too far, for it should be recollected that a certain amount of inflammation is absolutely necessary to insure the restoration of the injured structures. If, therefore, the depletion be pushed to an inordinate extent, the system may be so far exhausted by it as to be unable to furnish the parts with the requisite supply of blood and plasma to carry on the work of repair. Besides, it can hardly be doubted that very active measures, tending to add still further to the debility of the patient, can fail to prove prejudicial, by abstracting unduly the nervous influence of the brain, thereby seriously retarding, if not altogether preventing, recovery. On the other hand, too much forbearance must be equally disadvantageous. Hence, he will best discharge his duty who steers a strictly middle course, neither allowing himself too much freedom on the one hand, nor exhibiting too much inactivity on the other. Having removed all extraneous substances, and placed the parts, if accessible, as nearly as possible in their natural relations, the patient is carefully watched, any tendency to overaction being at once arrested by the lancet, leeches, and other means. Early recourse is had, in all cases, to active purgation, the best articles for the purpose being calomel and jalap, or infusion of senna and sulphate

of magnesia. When the patient has difficulty in swallowing, stimulating enemata must take the place of cathartics. Vomiting must, of course, be carefully guarded against, but when there is great dryness of skin, conjoined with an active pulse and excessive restlessness, there is no remedy more likely to promote perspiration, subdue vascular excitement, and tranquillize the system, than a solution of acetate of ammonia and veratrum viride, in union with morphia and tartar emetic, in the dose each of one eighth to the twelfth of a grain, frequently repeated until the object is effected. I am never afraid to employ either of the latter articles in wounds of the brain, after the system has been properly reduced by bleeding and purgatives, or when these means are rendered unnecessary by previous shock and loss of blood. The head, well shaved, is thoroughly elevated, and kept constantly covered with a bladder partially filled with pounded ice. Starvation is not carried too far, lest it should create irritability in the heart and brain; at the same time great care is taken that the diet is perfectly simple and non-stimulant. All excitement is avoided, both during the active treatment and for a long time afterwards.

An unaccountable prejudice has generally existed against the exhibition of anodynes in wounds of the brain and its envelops. Early in the disease they are, no doubt, usually injurious, but after due depletion has been practised, or when marked exhaustion has been induced by shock, loss of blood, or other causes, they not only prove eminently useful, but are absolutely indispensable to quiet the system and place the affected structures in a suitable condition for repair. Their effects should, of course, be sedulously watched, and, in most cases, they may be advantageously combined with some diaphoretic, as ipecacuanha, tartar emetic, or the neutral mixture.

Cases occasionally occur in which a portion of brain is lost, and a piece of the broken bone is forced down beyond the surrounding level, so as to occupy its place. If, in such a condition, there are no symptoms of compression, it will be well, as was long ago suggested by Sir Astley Cooper, not to disturb the depressed fragment, as the operation would be very liable to be followed by undue inflammation and by the development of fungus, if not also by extravasation of blood, thus greatly lessening the chances of recovery. Any loose splinters that may be present should, of course, be at once removed, especially if they impinge upon the brain and its envelops.

SECT. VIII.—FUNGUS OF THE BRAIN.

This affection, sometimes, ridiculously enough, called hernia of the brain, consists in a protrusion of cerebral substance through an opening in the skull, accompanied by a laceration of the brain and its envelops. It occasionally follows caries of the cranial bones and disease of the dura mater. One of the worst cases that I have ever seen was produced by syphilitic ulceration of the skull. When it supervenes upon external violence, it generally makes its appearance within a few days after the accident, and sometimes, indeed, almost immediately, especially when the cerebral lesion is unusually extensive. Its progress is commonly very rapid, the growth often attaining the size of a hen's egg in less than a week. Pressure has a tendency to restrain it, and to limit its bulk. The form of the tumor bears a considerable resemblance to that of a mushroom, the expanded portion overhanging the skull, while the narrow, projecting through the abnormal opening, is connected with the brain below. Its surface is rough, incrustated with grayish, dirty colored lymph, and bathed with fetid, ichorous matter; in some cases it is studded with fungous granulations. The appearances of cerebral fungus are well illustrated in fig. 92, from one of my patients. The fracture was situated at the outer and inferior portion of the frontal bone.

Fig. 92.



Fungus of the Brain after Fracture.

The form of the tumor bears a considerable resemblance to that of a mushroom, the expanded portion overhanging the skull, while the narrow, projecting through the abnormal opening, is connected with the brain below. Its surface is rough, incrustated with grayish, dirty colored lymph, and bathed with fetid, ichorous matter; in some cases it is studded with fungous granulations. The appearances of cerebral fungus are well illustrated in fig. 92, from one of my patients. The fracture was situated at the outer and inferior portion of the frontal bone.

If a section be made of the fungus, it will be found to be composed of a mixture of cerebral substance and plastic matter, sometimes the one, sometimes the other, predominating. When the growth is recent and rapid,

it is not unusual for it to contain small masses of clotted blood, similar to apoplectic depôts of the brain. Its structure is usually very vascular, and it, therefore, often bleeds quite freely when cut, or even when roughly handled. Destitute of sensibility, it is elastic and compressible, moving synchronously with the pulsations of the brain. That this tumor is not composed entirely, or even in great measure, of cerebral matter, as has sometimes been supposed, is proved by the circumstance that, after death, the loss of brain does not at all correspond with the volume of the morbid growth and the repeated retrenchments to which it was subjected during life. If this were the case, we should often find the greater portion of one entire lobe destroyed, or, at all events, an immense cavern in the affected hemisphere; but such, except in a few rare instances, is not the fact. The cerebral tissues around the tumor are always softened, discolored, and more or less infiltrated with serosity.

It is impossible to confound this morbid growth with any other, its history, the rapidity of its development, and the peculiarity of its shape, being always sufficient to mark its character. The symptoms which accompany it are variable. The discharge is usually thin and ichorous, very profuse, and excessively fetid. Frequent bleeding occurs. The mind is sometimes affected from the very first; at other times it is perfectly clear and calm for days and weeks together. In general, however, there is considerable cerebral disturbance, as indicated by the delirium and by the incoherent answers of the patient; the countenance has a peculiarly vacant expression; the skin is dry and harsh; the pulse, seldom normal, is either too rapid, or, as more commonly happens, too slow; the secretions are deranged; the bowels are constipated; and the sleep is interrupted by frequent starts and twitches. As the disease nears its close, coma and convulsions set in, and the patient dies, gradually exhausted, from nervous irritation. Recovery is an extremely rare occurrence in any case, however simple.

In the *treatment* of this affection, in its earlier stages, before the tumor has made much progress at extrusion, well conducted, systematic compression constitutes the most important feature. The object is to restrain the growth, and to circumscribe its limits. The pressure is made with a piece of compressed sponge, and a roller, changed as often as may be necessary to insure firmness and cleanliness. As the mass recedes, the sponge gradually sinks into the osseous opening, until it is reduced to the level of the brain. To prevent relapse, the pressure is steadily maintained, now, of course, more gently, up to the very point of cicatrization. When, through neglect or mismanagement, the protrusion is unusually large, the proper plan is to excise all that is accessible, or to destroy it with the Vienna paste, or, what in my opinion is preferable, the actual cautery, the parts being afterwards protected in the manner just indicated. When the discharge is very offensive, free use is made of chlorinated soda, or permanganate of potassa. The patient's strength is supported by tonics and a mild but nutritious diet. The head is maintained in an elevated position, and all excitement carefully avoided. Sometimes the fungous mass, becoming strangulated by the edge of the orifice in the skull, loses its vitality, and drops off; rarely, however, with any permanent advantage.

SECT. IX.—INJURIES OF THE CEREBRAL NERVES.

Fractures of the skull are not unfrequently attended by serious lesion of the cerebral nerves, which, in their passage through the different openings at the base of the cranium, are liable to be contused, lacerated, and even completely cut asunder by the sharp edges of the osseous fragments, or by the vulnerating body, as in gunshot and other injuries. The nerves most prone to suffer in this manner are the auditory and facial, as they lie in the internal auditory meatus. Sometimes the mischief is induced by the compression experienced by some of these cords from displaced bone or extravasated blood, whether external to them or within their neurilemma. Occasionally, again, the injury is manifestly dependent upon mere concussion of the nerve-pulp.

The symptoms attendant upon these lesions vary according to the nature of the affected nerve, as to whether it is one of motion, sensation, or respiration. When a nerve of motion suffers, there must necessarily be paralysis of the parts supplied by it, the deprivation of function being either partial or complete, according to the extent of the injury. In fracture of the base of the skull, palsy of one side of the face is a frequent phenomenon, noticed from the earliest periods of the profession.

Paralysis of the upper eyelid, technically called ptosis, may be caused by injury of the third pair of nerves, more generally by pressure from extravasated blood than by contusion or laceration, both of which are very uncommon here. In some of the recorded cases of this affection, the ptosis was associated with dilatation of the corresponding pupil and paralysis of other parts of the body. The fourth pair of nerves, owing to its protected situation, enjoys a remarkable immunity from injury in fracture of the base of the cranium. When the fifth pair is wounded or compressed, the most important symptom is loss of sensibility of the face, accompanied, in severe cases, by a similar condition of the tongue and nose. When the sixth cerebral nerve is compressed or lacerated, convergent strabismus is liable to follow, from paralysis of the external straight muscle of the eye. Loss of hearing, sight, and smell ensues upon injury, respectively, of the auditory, optic, and olfactory nerves. It is worthy of note that facial paralysis may exist without deafness, and conversely. Injury of the pneumogastric, glosso-pharyngeal, hypoglossal, and spinal accessory nerves is attended with dyspnoea, aphonia, dysphagia, and torpor of the stomach.

Loss of smell may be caused by direct injury, as in fracture of the frontal and ethmoid bones, or indirectly, as when the injury has been inflicted upon the occiput or top of the head. In a paper by Dr. Ogle, on Anosmia, in the *Medico-Chirurgical Transactions of London* for 1870, two cases are reported in which this effect was produced by a blow upon the occiput, followed, as was supposed, by rupture of the olfactory nerves as they pass from the bulb through the holes in the ethmoid bone. A blow not violent enough to inflict serious mischief upon the anterior lobe of the cerebrum may, nevertheless, be sufficient to lacerate these nerves, owing to their excessive softness and delicacy. Anosmia is sometimes associated with loss of taste, and the concurrence of anosmia and aphasia is by no means uncommon.

Some of these affections subside spontaneously or under the influence of appropriate medication; others are incurable. When there is reason to believe that the cause of the trouble is compression from extravasation of blood, a mild course of mercury with iodide of potassium, and steady but gentle purgation, might be useful; but, under opposite circumstances, the case is generally hopeless.

SECT. X.—INTERCURRENT EFFECTS.

Various affections are liable to arise after injuries of the head, more or less seriously complicating the original accident. Of these affections the most common are erysipelas, pyemia, pneumonia, hectic irritation, and profuse suppuration. Tetanus is a very rare occurrence. More or less traumatic fever, of course, generally attends, but of this no particular account need here be given.

1. *Erysipelas*, as an effect of injuries of the head, is exceedingly common, especially in camps and hospitals, in persons of dilapidated health and intemperate habits. It generally comes on within the first three or four days of the accident, for the most part upon the scalp and face, but sometimes also upon the trunk and the extremities, and constitutes one of the most serious complications to which a patient, in this condition, is liable. It may follow the most insignificant as well as the most violent injury, as the merest scratch or puncture of the scalp, and is especially dangerous when it breaks out upon the head, from the proximity of the affected structures to the meninges of the brain. It often spreads with great rapidity, and terminates fatally in a very short time. Its advent is usually announced by rigors and high fever, speedily followed by delirium and a typhoid condition of the system. The treatment is by leeches, blisters to the scalp, and other antiphlogistic remedies. Anodyne and other supporting measures will be required when there is excessive prostration.

2. Among the more common of the intercurrent effects of these injuries is *pyemia*, with abscesses and purulent effusions in different parts of the body, connected either very remotely or not at all with the head. The organs which are most liable to suffer in this manner are the lungs and the liver. Collections of pus also sometimes occur within and around the larger joints, and in the connective tissue beneath the skin and among the muscles. Abscesses of the internal organs, especially of the lungs and the liver, may coexist with suppurative inflammation of the brain and its meninges, or they may occur entirely independently of it, as a result simply of inflammation of the intracranial contents, the scalp, the pericranium, or the osseous tissue.

Pyemic abscesses are particularly liable to form in the lungs during the progress of injuries of the head. The connection between injuries of the brain and abscesses

of the liver has long been noticed. Many examples illustrative of the fact are to be found in the writings of the older surgeons, more especially among the contributors to the Memoirs of the Royal Academy of Surgery of Paris. It was supposed, until a comparatively recent period, that the liver was more liable to suffer in this manner than the lungs; but experience has proved that this is not the case, the former of these organs occupying a very decided precedence, as it respects the development of pyemic abscesses after all injuries, of whatever character. Thus, of eighteen examples of cerebral injuries observed by Mr. Prescott Hewett, abscesses were found in the lungs in thirteen cases, and in only three in the liver. The spleen and the kidneys rarely suffer. Marchetti met with an instance of pyemic abscess in the heart, after an injury of the skull.

These secondary abscesses may follow upon the slightest as well as upon the most severe lesions of the head. A mere contusion of the scalp, so insignificant as hardly, at first, to attract any attention, has sometimes led to suppurative inflammation of the lungs, liver, and other internal organs. Concussion of the brain, the result of a slight blow, has been known to give rise to it. By far the most frequent cause of all, however, is inflammation of the diploic structure of the skull, whether occasioned by an extension of disease from the scalp, or by direct injury inflicted upon the spongy texture itself, as when it has been more or less severely contused, or exposed by a gunshot fracture, the ball plowing through the outer table. The veins of the diploë, which are both large and numerous, readily take on inflammation in this condition, soon terminating in the formation of thrombi, which, becoming disintegrated and being carried into the circulation, are arrested in the parenchyma of the organs, and thus lay, by the irritation they excite, the foundation of embolic abscesses.

The period which intervenes between the primary injury and the supervention of these abscesses is frequently very short, not, perhaps, exceeding five or six days. On the other hand, a number of weeks may elapse. Hennen has recorded a remarkable case of a woman in whose liver pus was found within less than two days of the receipt of a blow upon the head.

The symptoms declarative of these secondary occurrences are usually of a very insidious character, the most important being rigors, or creeping, chilly sensations, alternating with flushes of heat, high constitutional excitement, excessive restlessness, and great prostration, rapidly followed by delirium and death.

The diagnosis of this form of abscess in the lungs is very equivocal. The respiration is more or less embarrassed, as in ordinary pneumonia, but, as the abscesses are small, the pulmonary tissues admit air so freely as not to cause any material alteration in the respiratory murmur, and in the sounds of the chest. In metastatic abscesses of the liver a jaundiced appearance of the skin and pain in the right hypochondriac region, along with bilious vomiting, have occasionally been noticed. Abscesses of the spleen and kidneys cannot be distinguished from other acute diseases of these organs. Purulent collections in and around the joints and in the connective tissue under the skin and among the muscles, are characterized by the ordinary phenomena.

The prognosis is most unfavorable. In the more simple forms of pyemia, marked merely by chilly sensations and slight febrile movements, recovery is, I think, possible; but when abscesses form in the lungs and liver, or even in one of these organs, death is inevitable.

These metastatic abscesses are usually very small; but, on the other hand, often very numerous, especially in the more protracted cases, the great majority of them being situated either upon the surface of the affected organ, or immediately beneath its lining membrane. The matter is of a whitish or yellowish hue, and generally of a thin, cream-like consistence, often interspersed with flakes of lymph. The surrounding tissues are softened and abnormally red, and the veins are commonly occupied by fibrinous concretions. In the lungs these abscesses are sometimes accompanied by sero-purulent effusions in the pleural cavities, and in the liver, very generally, by suppurative portal phlebitis.

The treatment of pyemia with its attendant abscesses must be of a supporting character, consisting of quinine, iron, carbonate of ammonia, brandy, and a good supply of fresh air, with a sufficiency of anodyne medicines to allay pain and induce sleep. External abscesses are opened in the usual manner.

3. Inflammation of the *lungs*, as an intercurrent disease in injuries of the head, is

most common in elderly, dilapidated, and intemperate subjects, long confined in the same posture, or the subjects of cold prior to the occurrence of the accident. Such cases should always be well watched, lest the inflammation make destructive progress before its true nature is detected. The treatment is conducted upon ordinary medical principles, cupping, vesication, and general supporting measures forming the more important remedies.

4. *Hectic irritation* is a common occurrence after head-injuries, more especially in compound fractures, involving the brain and its membranes, and attended with profuse discharge of pus. The symptoms characterizing this condition bear so close a resemblance to those attendant upon pyemia as to defy accuracy of diagnosis. The treatment must be largely of a supporting nature.

5. *Tetanus* is an occasional consequence of injury of the head, but much less frequently than is generally supposed. In the tables of Mr. Curling, embracing 128 cases of traumatic tetanus, the wounds in 11 were either on the scalp or on the face. The treatment calls for nothing of a peculiar character.

6. The tendency to *relapse*, after injuries of the head, has long been familiar to surgeons, and cannot be too strongly insisted upon. "Slow as the brain is in some cases," says Hennen, "to take on diseased action, it is amazingly irritable in others." Hence, the patient cannot be too sedulously watched, or subjected to too rigid hygienic regulations, even after the most insignificant lesion, whether of the scalp, the cranial bones, or the brain and its membranes. Every symptom, however trivial, should not only be regarded with suspicion, but most rigorously scrutinized, with a view, if possible, of determining its pathological import.

SECT. XI.—CAUSES OF DEATH.

The causes of death in injuries of the head vary with many circumstances. Among the more common are, 1st, shock; 2dly, extravasation of blood; 3dly, inflammation of the affected structures; 4thly, various kinds of fractures; 5thly, erysipelas; 6thly, pyemia; 7thly, tetanus.

1. More or less shock attends every case, however slight, of injury of the brain. When very severe, death may follow instantaneously, or, at furthest, within the first few hours, without, in many instances, the slightest attempt at reaction, the patient lying in a pale and unconscious condition from the moment of the accident up to that of dissolution. Or, reaction having occurred, the vital powers may again flag, and death ensue before the inflammatory stage is reached.

2. Extravasation of blood, causing compression of the brain, is a very frequent cause of death. When the quantity of blood is very small and the case does not present any serious complications, the brain may gradually accommodate itself to the adventitious matter, eventuating in complete recovery; but when the reverse is the case, the accident nearly always proves fatal, either during the first few days, or after the establishment of inflammation.

3. Encephalitis, especially if accompanied by inflammatory deposits, is almost invariably fatal, the patient dying in a state of coma, preceded by paralysis and convulsions.

4. Fractures of the skull are always dangerous occurrences, often not so much on their own account as on account of the injury that is inflicted upon the brain and its membranes. Punctured, compound and gunshot fractures, and fractures at the base of the skull, are a frequent source of death, however judiciously treated, the patient dying either of shock, of hemorrhage, or of inflammation.

5. Death in injuries of the head frequently results from erysipelas and pyemia, the slightest causes occasionally provoking their attack. Congestion of the lungs is always a dangerous complication, especially in persons of advanced age, or even in the young, if compelled to remain for a long time in the supine posture. Tetanus is occasionally a cause of death, but, probably, much less frequently than is commonly imagined.

6. The mortality after injuries of the scalp, skull, brain, and meninges is greater, other things being equal, in hospital than in civil practice, especially when, as in time of war, many wounded are crowded together in the same wards, without proper ventilation.

7. Operations performed for the relief of traumatic lesions of the head, as has been shown elsewhere, seldom prove fatal from any injury that is inflicted by them,

but simply, or mainly, because of the serious character of the injury for which they are generally undertaken. Although this statement has many exceptions, yet, as a rule, it is believed to be perfectly true.

SECT. XII.—SECONDARY AFFECTIONS.

Injuries of the skull and brain, and, indeed, even of the scalp itself, are liable to be followed by certain affections which, as they come on at a variable period after the occurrence of the original lesion, may be denominated secondary. These affections have reference more particularly to the condition of the mental faculties, the special senses, the muscular powers, and the functions of certain organs. They supervene upon the slightest accidents hardly less frequently than upon the more severe, and exhibit themselves in a great variety of forms, the precise nature of which it is often difficult, if not impossible, to comprehend or to interpret. That this should be the case is not surprising when it is remembered how little is really known respecting the functions of the various component structures of the brain. These secondary effects are sometimes observable at a very early period after the infliction of the injury, whereas at other times they do not appear until long after.

Among the more common of the mental conditions is a loss of memory. This often exists in a very remarkable degree, either by itself or in association with other affections. In the great majority of cases it refers only to recent events; but occasionally it involves every circumstance in the history of the individual's life, past and present. Sometimes he talks with all the garrulity of old age of the occurrences of his childhood, miscalls objects, or is unable to connect his words, or to pronounce certain letters. Instances have come under my observation in which the patient could not recollect his own name, the country of his nativity, or his present residence. Every student of surgery is familiar with the case recorded by Sir Astley Cooper, of a Welshman who, in consequence of a blow upon the head, completely lost his knowledge of the English language, which he had spoken fluently before the accident.

One of the most distressing of the remote effects of injuries of the head is mental alienation. Of 500 cases of insanity analyzed by Schlager, the disease in 49 was directly traceable to the effects of concussion of the brain, the affection in 19 supervening within the first twelve months, and the others at a later period. The prognosis in such cases is always unfavorable. The most common morbid appearances observed in those who die after such occurrences are, bony deposits upon the surface of the skull, adhesions between the dura mater and the brain, subarachnoid infiltration, effusions into the ventricles, and local atrophy of the cerebral tissues.

Occasionally the mind is merely weakened, or slightly crippled in some of its functions. A complete change of the moral feelings is sometimes noticed. Again, a person, instead of being gentle and quiet in his demeanor, as he was previously to the accident, may be morose, captious, or quarrelsome. Sometimes the effect shows itself in disturbed sleep, in frightful dreams, in excessive irritability of temper, or in inaptitude for business, the mind becoming blunted and incapable of the slightest exertion. Children sometimes suffer from chorea. Pain in the head, dizziness, vertigo, noises in the ears, and a haggard expression of the countenance, are among the occasional occurrences. Epilepsy is another, although, happily, an uncommon, sequel. It is, judging from personal observation, most common after fractures of the skull, attended with depression of bone.

Special sensation is often greatly impaired, and, sometimes, even completely annihilated. Thus, there may be more or less deafness, impaired vision, contracted or dilated pupil, loss of smell, disordered taste, or diminished feeling in the skin. Or, on the other hand, special sensation may be unnaturally exalted. Of these accidents special mention has already been made in the section on injuries of the nerves.

Aphasia is an occasional sequel of injury of the brain, more especially of its anterior lobes. The person, in this condition, is able to talk, but, not recollecting words, he fails to convey his meaning, or to render himself intelligible. Generally, indeed, he employs the same expressions whenever he attempts to speak. The distinction between aphasia, depending upon loss of memory, and the want of ability to articulate or talk, depending upon paralysis of the muscles of the tongue and lips, is readily determined by the fact that, in the latter case, the individual is

always able to make himself understood by means of his pen. Occasionally both memory and speech are extinct. These affections, which have recently been ably investigated by Bateman and Falret, are usually permanent.

The effects of compression of the brain from depressed bone upon the bodily and mental functions are strikingly illustrated in the remarkable case recorded by Sir Astley Cooper. The subject, a sailor, had remained in a state of unconsciousness upwards of eleven months, in consequence of a fracture of the superior portion of the left parietal bone. When admitted into St. Thomas's Hospital he was, in great degree, destitute of sensation and voluntary motion. When hungry he was wont to grind his teeth, when thirsty to suck his lips, and when he wished to relieve his bowels and bladder to move about in bed. His pulse was regular, but his fingers were in a constant state of flexion and extension, nearly corresponding in frequency with the heart's action. During the removal of the depressed bone, he made a noise of complaint, and the motion of his hands ceased. A few hours after the operation he was able to sit up in bed, and he put his hand to the wounded part when asked whether he was in pain. The next day he could say yes and no, but had still some stupor. He gradually recovered; and, when questioned as to the last thing that he remembered, it was taking a prize in the Mediterranean nearly one year before.

Some very curious examples have been recorded in which injuries of the head were followed by great improvement, if not the actual restoration, of some lost function or special sense. Hyslop gives the case of an old lady who, after having been deaf from her infancy, permanently regained her hearing after a severe concussion of the brain. A similar case is mentioned by Liston. An old nurse, whose hearing had long been so obtuse as to compel her to discontinue her occupation, on recovering from a severe injury of the skull attended with concussion, experienced such acute distress in her ears that the slightest noise, even the ticking of the clock in her room, became a source of the greatest annoyance to her. A case of complete restoration to reason after an attack of insanity occurred to Desault. Pope Clement VI. found his memory greatly strengthened after a slight concussion of the brain. "It is a well-established fact," says Dr. Forbes Winslow, "that idiocy, apparently irremediable, connate imbecility, has been cured by a blow upon the head." The same writer relates the case of a woman who, on awakening from the effects of a slight concussion of the brain, caused by a fall from a third-story window, almost instantly recovered from an attack of acute puerperal mania, attended with excessive raving and restlessness. I have known several instances in which the intellect was wonderfully sharpened after the loss of a considerable quantity of cerebral substance. Mabillon, a Catholic priest, in his younger days an idiot, only obtained the full use of his mental faculties after he was trephined, at the age of twenty-six, on account of a fracture of the skull. His memory, it is said, became remarkably acute, and his imagination very lively.

Among the more remarkable sequences of injury of the brain, especially of concussion, is an unnatural slowness of the pulse; the occurrence is most common in lesions of the base of the organ, particularly of the medulla oblongata, the bridge of Varolius, and the cerebral crura, and often persists for several months after the disappearance of all the other symptoms. A remarkable feature in this condition of the pulse is the readiness with which, when the patient is excited, it is changed into quickness.

Sometimes the secondary effect manifests itself in a disordered condition of the liver, as denoted by the icterode state of the skin. Nausea and vomiting are occasional occurrences; and cases are met with in which the chief symptom is constipation of the bowels. When the gastric distress is uncommonly obstinate and protracted, it may be assumed that it is due to direct involvement of the pneumogastric nerves. The assimilative functions are sometimes greatly at fault, the patient becoming gradually emaciated, and deprived of strength, notwithstanding a good condition of the appetite.

Trouble in the urinary organs is occasionally experienced, consisting in irritability of the bladder, incontinence or retention of urine, and in various alterations in the composition and quantity of the renal secretion, which is sometimes enormously increased, the occurrence usually manifesting itself within a short time of the accident, and generally disappearing in eight or ten days, although cases are met with where it continues for several months. Traumatic diabetes is nearly always of the

saccharine character, the amount of sugar being, however, commonly very small. An albuminous condition of the urine, with or without a diminution of urea, is occasionally noticed, especially after the more severe forms of injuries of the skull and brain.

The occurrence of sugar in traumatic diabetes has been variously explained. Claude Bernard supposes that it is due to an increase in the abdominal circulation, in consequence of lesion sustained by the medulla oblongata, near the origin of the pneumogastric nerve, by which the excess of sugar in the blood of the liver is sent to the kidneys. Szokalski attributes it to concussion of the floor of the fourth ventricle, the glycogenic centre, if we may credit the results of the experiments of the French physiologist. Reynoso imagines that the phenomenon is caused by defective oxygenization of the blood and the imperfect destruction of the saccharine matter of that fluid. Whether any of these views are correct, future observation must determine.

The genital organs sometimes suffer. Violent and uncontrollable sexual excitement, attended with incessant erections, sometimes occurs, generally as a consequence of injury of the back of the head, involving the cerebellum, and coming on soon after the accident. On the other hand, lesions of this kind may be followed by impotence, either with or without atrophy of the testes.

Muscular twitches, and paralysis of certain muscles, are occasional occurrences after injuries of the head. They are most common in the muscles of the face and eyes, where they are often productive of great deformity. A whole limb, a hand, or a finger is sometimes paralyzed; or, instead of being paralyzed, there may be a want of coördination between certain muscles, thereby interfering with the normal functions of the parts.

Lesions of the scalp are liable to be followed by unpleasant secondary effects. Of these affections the most common and distressing are neuralgia and morbid sensibility in the inodular tissues, often difficult to cure, and, in the end, productive of more or less serious disorder of the general health.

What the pathology of these various secondary affections is cannot generally be determined, as dissection seldom throws any light upon it. They are, probably, however, in the great majority of cases, dependent upon local congestion, irritation, or inflammation of particular parts of the brain, or of the brain and its envelops, upon laceration of the cerebral substance, upon the presence of extravasated blood, serum, or lymph, or upon injury of the cerebral nerves.

Among the more remote effects of injuries of the skull and brain bearing directly upon their pathology, is one recently brought to light by the researches of Virchow. It consists in calcification and necrosis of the ganglion-cells, along with their processes, and sometimes also of the fine nerve-fibres in the cortical substance of the periphery of the brain. The change, which is of very frequent occurrence after fractures and fissures of the skull, is evidently due to the commotion experienced by the cerebral tissues at the time of the accident, and is often, if, indeed, not generally, associated with atrophic depressions, brownish cicatrices, red softening, or yellowish plates, not always discernible by the naked eye. The diseased ganglion-cells can only be detected with the microscope.

The *treatment* of these various affections must, of course, be in great measure empirical; but, however this may be, it should always be particularly directed to the head and alimentary canal, consisting mainly of local depletion, quietude of mind and body, the administration of purgatives, an occasional emetic, counter-irritation, especially of the pyrogenic kind, and a careful regulation of the diet. A gentle course of mercury is sometimes beneficial, and in most cases signal advantage will accrue from change of air, tonics, and the cold shower-bath, with dry friction.

In the management of traumatic inflammation of the brain and of its envelops, both primary and secondary, special inquiry should be made, from time to time, into the condition of the more important viscera, particularly of the kidneys, as any serious intercurrent lesion on their part may occasion symptoms closely simulating those produced by injury of the head, and thus lead to essential modifications in the diagnosis and treatment of the case.

SECT. XIII.—OPERATION OF TREPHINING.

The circumstances which require this operation are:—1. Compound fractures with depression of the bone, with or without symptoms of compression. 2. Simple fractures with depression and symptoms of compression after a fair trial of ordinary means. 3. Punctured fractures, no matter what may be the condition of the brain. 4. Extravasation of blood between the skull and dura mater, or in the arachnoid sac on the cerebral hemispheres. 5. The existence of pus in the same situations. 6. Foreign bodies. 7. Epilepsy, and other secondary effects. A singular case has been recorded by Velpeau, in which the operation was performed on account of the presence of a lock of hair folded back upon the dura mater, and imprisoned between the edges of the fracture.

In performing the operation, the patient is placed upon a narrow dining-table, or lounge, the head and shoulders being properly elevated by pillows, covered with a sheet and a piece of oil-cloth. If he is faint, the less the head is raised the better. The scalp being extensively shaved, the bone is exposed by a suitable incision, of which the semilunar, T-shaped, V-like, or crucial are the most common. Sometimes the bone is so much denuded by the accident as to render but little dissection necessary. In no event should any portion of the scalp, however severely lacerated or contused, be cut away. The bleeding which follows the use of the knife either ceases

spontaneously in a few minutes, or is easily arrested by the ligature, although this should always, if possible, be avoided, as it has a tendency to interfere with the adhesive process. The periosteum, upon the integrity of which the welfare of the bone so essentially depends, is cautiously dealt with, the flaps being, if practicable, drawn towards the sides of the wound, and carefully held there until the operation is completed. If more attention were paid to this subject, there would, I am sure, be much less danger of exfoliation of the bone; an occurrence which often greatly retards the cicatrization of the parts, and leads to much pain and inconvenience. All scraping is inadmissible.

The crown of the trephine, of which there should be several sizes, is planted upon a sound portion of bone, as in fig. 93, to a degree just sufficient for the accommodation of the centre-pin, which is always protruded at the moment of the application. The instrument is then moved by semicircular sweeps from left to right and right to left, until it has formed a groove deep enough to maintain its place, when the pin is permanently retracted,

lest, upon reaching the inner table, it pierce the cranial contents. The sawdust is removed from time to time from the trephine with a brush, or, what is preferable, a wet sponge, and from the track in the bone with a toothpick. Approach to the diploë, if any be present, is indicated by greater freedom of motion, a more abundant flow of blood, and a less grating sound. The instrument is now turned with more and more caution, and in such a way as to divide the inner table simultaneously at every point. There is no necessity for any hurry; the patient is frequently insensible from the accident, or is rendered so by chloroform, and hence the whole proceeding is conducted in the most deliberate manner, the operator constantly bearing in mind that any injury, however slight, which he may inflict upon the brain and its membranes, may seriously compromise the patient's safety. The disk of bone often comes away in the saw: when it does not, it is readily raised with the finger, forceps, or elevator. All depressed pieces of bone are next raised, and all loose ones removed. The edges of the osseous orifice are smoothed with a raspator, blood and other extraneous matter are carefully cleared away, bleeding vessels are tied, and the wound in the scalp is accurately secured by suture and plaster, a small interspace being left for drainage, unless there is the strongest reason to believe, from the appearance of the parts, that they will unite by the first intention. Over this dressing is applied a tolerably stout compress, confined by a roller, to support the beating brain, and prevent the occurrence of fungus.

The annexed cut, fig. 94, represents the trephine which, from long habit in its use,

Fig. 93.



Application of the Trephine.

I prefer to any other. It is a very beautiful instrument, and such is the facility with which it may be worked that, unless the skull is of extraordinary density, the

Fig. 94.



Common Fluted Trephine.

Fig. 95.



Different Forms of Saws.

Fig. 96.



Different Forms of Elevators.

operation may generally be accomplished in a very short time. The other instruments which usually accompany the trephine are a pair of Hey's saws, fig. 95, or, more properly speaking, the saws of Scultetus, an elevator, fig. 96, a lenticular, fig. 97, and a raspatory.

Fig. 97.



Lenticular.

The old conical trephine, depicted in the works of Paré, Heister, and others, was reintroduced to the notice of the profession by Dr. Galt, of Virginia, in 1860. It consists, as seen in fig. 98, of a truncated cone, the surface of which is furnished with numerous sharp spiral teeth, which thus greatly facilitate the perforation of the bone, while the instrument, from its peculiar shape, ceases to act the moment the penetration is effected, and so prevents all risk of injury to the brain and its membranes.

The saw of Scultetus may often be advantageously employed in removing an overhanging ledge of bone, thereby facilitating the elevation of the depressed fragments, so that the use of the trephine may, perhaps, be entirely dispensed with. Sometimes, again, a portion of the margin of the fracture may readily be chipped away with a small chisel and hammer. The treatment is particularly applicable to the comminuted form of fracture, attended with extensive splintering of the inner table.

There are certain points of the skull where, if it be possible to avoid it, the trephine is never applied. These points are the frontal sinus, the anterior inferior angle of the parietal bone, the course of the longitudinal sinus, the occipital protuberance, and the different sutures. The reasons for this injunction are suffi-

Fig. 98.



Conical Screw Trephine.

ciently obvious. Exposure of the frontal sinus might lead to a fistulous orifice, attended with a constant escape of air and mucus; at the second place indicated is the middle artery of the dura mater, running sometimes in a deep furrow of the bone; at the top of the skull is the longitudinal sinus; and in the occipital region there is not only inordinate thickness of bone, but danger of interfering with the lateral sinus. Should an operation at any of these situations become imperative, the greatest caution should be employed in its execution. When the frontal sinus is obliged to be penetrated, two trephines must be used, a large one for the external table, and a smaller one for the internal.

The operation being over, the patient is placed in bed with his head and shoulders well elevated, and subjected to the most rigid antiphlogistic regimen. The great danger, of course, is inflammation of the brain and its meninges, and hence the head should be most diligently watched, in order that the earliest moment may be seized to counteract the slightest untoward occurrence. The dressings are removed from time to time, as they become soiled, or a source of irritation, and great care is taken that the formation of pus beneath the replaced scalp does not become a cause of cerebral oppression. Should this be found to be the case, the dressings must immediately be removed, and, if necessary, a puncture made through the superimposed parts, to afford a proper outlet to the pent-up fluid.

The opening left by the trephine is generally closed by fibrous tissue; sometimes by fibro-cartilage, and occasionally, though very rarely, by a thin stratum of osseous substance. The site of the injury is ever afterwards indicated by a depression in the skull, and for a long time the pulsations of the brain are perceptible through the adventitious structure. As this matter remains weak and thin for years, and, consequently, affords but a very imperfect protection to the brain, the opening should be kept constantly covered with some suitable contrivance, as a piece of leather, silver, or gutta-percha. For want of this precaution, fatal accidents have occasionally occurred.

The operation of trephining in civil practice has been followed by different results in the hands of different surgeons. In general, they are anything but flattering. In the hospitals of Paris and Vienna the operation is nearly always fatal; in London, Dublin, Edinburgh, Glasgow, and other large cities of Great Britain, the mortality, although also very high, is much less; and in the United States, the number of recoveries in proportion to the number of deaths is, as nearly as can be arrived at, as one to four. From the statistical accounts by Dr. Lente of fractures of the skull in the New York Hospital, it appears that eleven cases out of forty-five that were subjected to this operation were cured. There is reason to believe that the greatest success of the trephine is to be found in private practice. My own experience has furnished me with a number of excellent recoveries, and many other surgeons have been equally fortunate. The mortality of the operation will, of course, be materially influenced by the nature of the case, the character of the existing complications, the habits of the patient, and various other circumstances. The operation itself is not free from danger, as is proved by the fact that it is often fatal when it is performed for the relief of epilepsy and other severe nervous symptoms, although a distinction, I conceive, should be drawn between such cases and those involving recent injuries. The chief sources of danger are erysipelas, encephalo-meningitis, pyemia, fungus of the brain, profuse suppuration, and hectic irritation.

Perforation of the skull for the relief of injuries seems to have been attended with extraordinary success in the hands of some of the older surgeons. Thus, as is stated by Guthrie, Saviard trephined one person twenty times. Martel and Le Gendre, surgeons to the King of Navarre, in 1686, took away nearly the whole of both parietal bones, and yet the patient made an excellent recovery. Marechal applied the trephine successfully twelve times; Gooch thirteen times, and Desportes twelve times. Schmucker relates a case where the operation was performed eleven times in less than one month, and so little, he adds, was the patient incommoded by it that he seldom even went to bed after it. But the most remarkable instance of the kind upon record, one which throws all others into the shade, was that of Philip, Count of Nassau, who, in a fall from his horse, struck his head against the stump of a tree, and fractured his skull in several places. He was trephined twenty-seven times by Henry Chadborn, a surgeon of Neomagen, to whom, after his recovery, he gave a certificate as a proof of skill.

The most extensive use of the trephine, in modern times, was in a case referred

to by Mr. Guthrie, in his work on "Injuries of the Head," as having been furnished him by Dr. Evans. The case was one of fracture of the skull, involving the internal table much more extensively than the external. Twelve perforations with the trephine were required before the depressed bone could be elevated, and even then the symptoms of compression were not relieved until some extravasated blood was evacuated by incising the dura mater. Complete recovery ensued.

How remarkably tolerant the head occasionally is of great loss of bone, is shown in the cases recorded by Vigoroux and Saviard, in the former of which nearly the whole of the frontal bone, and in the latter almost the entire vault of the cranium, was destroyed, without causing death.

Age is no bar to the use of the trephine. The operation has often been performed with the most gratifying results in old people as well as in very young children. The latter, however, rarely require such interference, as the skull, even if considerably depressed, generally, in a few days, rises to its natural level through its own resilient powers, aided by the pulsative action of the brain. In a remarkable case, observed by Dr. Van Ingen, of Schenectady, a child, only twelve months old, was successfully trephined on account of a punctured fracture of the skull caused by a large nail, the disk of bone removed being nearly one inch in diameter. In performing the operation in early childhood, the utmost caution is required, otherwise, as the skull is very thin, and destitute of *deploë*, there will be great danger of wounding the membranes of the brain, the more especially as the dura mater always adheres with extraordinary firmness to the inner surface of the cranium.

Trephining in Epilepsy.—The operation of trephining is occasionally performed for the relief of epilepsy consequent upon neglected cases of depressed fracture of the skull. The first attempt of this kind was made by La Motte, in 1705, but only with partial success. In 1804, Mr. Cline, of London, recalled attention to it by the publication of a successful case; and since then it has repeatedly been performed for this purpose both in Europe and in this country. Dr. Dudley in 1828 published a valuable paper upon the subject in the first volume of the *Transylvania Journal of Medicine*, in which he detailed the particulars of five cases of epilepsy treated with the trephine, of which three were successful. The results of the practice of other surgeons have not, however, been so flattering. I have myself had occasion to perform the operation four times, with the effect of one cure and three deaths; and I have witnessed its execution in three other cases, all of which terminated fatally. Nearly all the patients perished within the first week from inflammation of the brain and its envelops, evidently induced, not by any direct injury inflicted upon these structures in the operation, but by the disturbance of the cerebral circulation consequent upon the removal of the depressed bone, notwithstanding the most thorough preparation of the system, and the most assiduous attention during the after-treatment. In one of my own cases, that of a man thirty-three years of age, whom I trephined at the College Clinic, in 1857, the cause of death was altogether unique. The depression, which had existed ever since he was eight years old, involved the upper portion of the parietal and frontal bones, being nearly two inches in diameter, by upwards of half an inch in depth at its centre. At the age of twenty-two, epileptic convulsions set in, and continued to recur, with increased severity and frequency, up to the time of the operation. Latterly his speech, memory, and general health had become so much impaired as to render him unfit for business. A large disk of the depressed bone being removed, the case seemed to progress favorably for forty-eight hours, when, stupor and spasms coming on, he gradually lapsed into a state of unconsciousness, and died five days afterwards. The dissection revealed the existence of extensive softening of the cerebral hemisphere at the site of the depression and an enormous effusion of black blood, with an opening in the membranes of the brain large enough to receive the end of the index finger. This opening, noticed at the time of the operation, was produced by the pressure of a small exostosis on the inner surface of the injured bone, permitting a free escape of the cephalo-spinal fluid, both during and after the operation. The pressure upon the brain being thus removed, the diseased vessels at the seat of the softening gave way, thereby causing fatal apoplexy.

Dr. John S. Billings has given an analysis of 72 cases of epilepsy, subjected to trephining, of which 42 were cured, 4 were unchanged, 16 proved fatal, and the remainder were improved, but not entirely relieved.

Finally, trephining is occasionally required for the removal of necrosed bone, per-

haps incarcerated by an overlapping ledge of the cranium. In a case of this kind under my charge, the sequester was not only prevented from escaping, in consequence of the narrow state of the opening in the skull, but the irritation which its pressure exerted upon the brain and its membranes was such as to cause repeated attacks of epilepsy, which promptly and permanently disappeared upon the extrusion of the offending substance.

SECT. XIV.—BANDAGES FOR THE HEAD.

For simply retaining dressings, cataplasms, and lotions upon the head, the best contrivance generally is a light handkerchief, arranged in the form of a nightcap, or a nightcap itself. The handkerchief being folded into a triangle, the centre of the base is applied to the forehead, and the body to the vertex, the tail hanging back over the neck. The side ends, lying upon the cheeks, are then carried backwards over the ears, crossed at the occiput, and tied in front, an inch above the nose, as represented in fig. 99. When greater nicety is required, as when the object is to

Fig. 99.



Handkerchief Bandage.

Fig. 100.



Recurrent Bandage.

make moderate but equable compression, a double-headed roller should be used, after the fashion shown in fig. 100. Its application is thus described by Mr. Lons-

Fig. 101.



Fig. 102.



Four-tailed Bandage for the Head.

dale: "The centre of the roller is placed low down on the forehead, and the two heads are carried back and made to cross low down beneath the occiput. One head is brought over the vertex, while the other is carried horizontally round to lap its

extremity; and this, turned up over the horizontal one, is carried back to the occiput, slightly overlapping the former vertical band. At the occiput, the heads are again crossed, the surgeon shifting his hands for the purpose, and a third turn is made on the other side of the vertical band, while a third horizontal round secures it as before. This is continued until the whole head has been uniformly invested."

The four-tailed bandage also answers a very useful purpose, especially for retaining dressings. Its application is shown in figs. 101 and 102. It consists of a piece of soft muslin, linen or calico, of the requisite length, split up nearly to the centre, in such a manner as to form four strips, the anterior of which are carried back and tied under the occiput, while the posterior are fastened under the chin. In some cases the position of the tail is reversed, according as the middle portion of the bandage rests on the forehead, chin, or occiput.

CHAPTER III.

DISEASES AND INJURIES OF THE SPINAL CORD, VERTEBRÆ, AND BACK.

THE most important surgical affections of the spinal cord are concussion, compression, sprains, inflammation, and wounds. The vertebræ are subject to curvature, tuberculosis, and congenital clefts, attended with protrusion of the arachnoid membrane, and constituting what is called hydrorachitis. Fractures and dislocations of the vertebræ are discussed at sufficient length in the first volume.

SECT. I.—CONCUSSION.

Concussion of the cord is produced by accidents similar to those which occasion concussion of the brain, as blows or falls upon the back, head, feet, or nates. The severity of the effect is usually in proportion to the directness of the injury; but the most violent and protracted case of concussion of the spine I have ever seen was caused by a fall, in an elderly gentleman, upon the buttocks, from a height of about ten feet, down upon the floor. Railway casualties are often attended by grave lesions of this kind, not unfrequently followed by a permanently crippled condition both of mind and body. The affection exists in various degrees, and probably does not always involve the entire cord, being limited to particular tracts of it, or concentrated with special force at particular points. However this may be, the symptoms are commonly very characteristic. The patient feels sick at the stomach, looks excessively pale, and is altogether helpless, his body being more or less paralyzed. A sense of formication, stinging, or prickling, is experienced along the spine and in the extremities; the sphincters are relaxed, and, in the more severe cases, there are apt to be involuntary discharges from the bladder and bowels. Death may occur from the severity of the injury within a short time after its infliction; or, reaction taking place, the effects of the concussion may gradually pass off, the limbs regaining their functions and the sphincters their power of action. In some cases, however, the mind remains bewildered for a number of days, the patient being partially delirious, but yet not sufficiently so to prevent him from washing and shaving himself, or even, perhaps, attending to business. Another remarkable symptom, which I have occasionally witnessed, after recovery from the more immediate effects of the injury, is excessive irritability of the bladder, attended with an almost incessant desire to pass water, which is generally greatly increased in quantity.

Concussion of the spine is often followed by extravasation of blood, occurring either at the moment, or within a variable period after the accident. The extravasation will be most likely to happen when the lesion is complicated with fracture of the vertebræ, a partial dislocation, or a severe wrench of the ligaments. It may, however, follow upon, apparently, very trivial injuries, simply from rupture of the vessels from the effects of shock. The blood may, as in the brain, lie between the wall of the vertebral canal and dura mater, in the arachnoid sac, upon the surface of the

cord underneath the pia mater, or in the substance of the cord, although the latter occurrence is very uncommon. The amount of extravasation varies, of course, in different cases, from a few drops to several drachms or even ounces. When the quantity is considerable, instantaneous paralysis in the parts below the seat of the effusion will be the result, either from its direct pressure influence upon the cord, or, indirectly, upon the roots of the spinal nerves. The paralysis may be complete or partial, and may affect both motion and sensation, or motion may be lost, and sensation be only slightly, if at all, impaired. In the worst forms of concussion of the spine, there is not only more or less effusion of blood in the situations here specified, but more or less extensive laceration of the lining membranes of the vertebral canal, and also, at least in many cases, of the spinal cord and of the roots of some of the spinal nerves.

The *prognosis*, in concussion of the spinal marrow, should be especially guarded, for no surgeon, however skilled in the art of diagnosis, can always tell, with any degree of certainty, the extent of the lesion. In the worst forms of the accident, death may be produced instantaneously, by mere shock; or, reaction occurring, life may be imperilled by the conjoint agency of concussion and inflammation. Occasionally an apparently slight concussion causes death; and, on the other hand, the most severe attacks may be recovered from. The restoration may be perfect, or some particular organ may remain in a crippled condition, manifesting itself in impairment, or, it may be, even in complete loss of function, as paralysis, or want of sensibility. Among the more uncommon effects of such lesions, after the patient has recovered from the more immediate effects of the accident, are hyperæsthesia and excessive mental irritability, accompanied by change of temper, and general disorder of the system, rendering the person unfit for active employment.

When the case is one of pure concussion, there is very little danger to be apprehended from secondary effects. There may, it is true, be some inflammation interfering with, or retarding, convalescence; but, with proper care and a little treatment, the disease soon vanishes, and the relief is complete and permanent. But it is far otherwise when there has been effusion of blood, laceration of the cord or of its envelops, or serious injury of the bony structure of the vertebral canal. Few patients ever recover when thus affected. Nature, however, assisted by art, is seldom able to effect repair. The extravasated blood, if not very large, may eventually be absorbed, and function, temporarily arrested by its presence, be gradually restored; but even such an occurrence is very uncommon, and can hardly be taken into the account in the consideration of the prognosis. Generally the more fluid parts alone are removed, the solid remaining, becoming organized, and keeping up injurious compression, thus interfering with the transmission of the nervous fluid.

Various secondary effects are liable to occur after concussion of the spine, as neuralgia of different parts of the body, partial or complete paralysis, muscular twitches, defective speech, atrophy of certain muscles, arrest of development, imperfect sexual power, and a want of control over the sphincter muscles of the anus and bladder. Occasionally the patient is permanently affected with retention or incontinence of urine.

The *treatment* of concussion of the spinal cord must be conducted upon the same general principles as that of concussion of the brain; by recumbency and cordials, or mild stimulants, during the stage of depression, and by more than ordinary vigilance during the period of reaction, lest the excitement should transcend the healthy limits and pass into inflammation. If the patient can swallow, brandy and aromatic spirit of ammonia should be given, or, if the power of deglutition be lost, these articles should be freely injected into the bowel; all constriction should promptly be removed; the fan should be actively used; the naked surface should be rapidly struck with the end of a towel wrung out of iced water; and the precordial region, spine, and extremities should be covered with sinapisms. A full dose of chloral, either alone or combined with a quarter of a grain of morphia, will generally speedily arrest the irritability of the bladder and the tendency to inordinate renal secretion. The confused condition of the mind may usually very well be left to the operation of time, as little reliance is to be placed upon any mode of medication for its relief. Perhaps the best medicine, if any be given for the purpose, is bromide of potassium, in moderately large and sustained doses.

After reaction is fully established, any tendency to undue excitement is promptly checked by the usual antiphlogistic measures; by the lancet, if the patient be strong

and vigorous, or, if not, by leeches to the spine, purgatives, aconite, diaphoretics, and a restricted diet. Counter-irritation by blisters is not neglected, if there is evidence of localized inflammation. Dry cupping is often very serviceable, and cases occur in which ice-bags stretched along the spine are beneficial. Anodynes are given to allay pain, to promote sleep, and to assist in controlling the heart's action.

The remote effects of concussion of the spine are best combated by sorbefacient remedies and attention to the general health. Iodide of potassium and bichloride of mercury are the most trustworthy internal articles, and ammoniated lotions with veratria the most valuable external ones. In obstinate cases slight but persistent ptialism will usually be necessary, aided by the application of the hot iron to the seat of the injury, indicated either by the existence of a tender spot of the spine, or by paralysis of the extremities. When the inflammation consequent upon the concussion has completely disappeared, and nothing remains but general debility, whether alone or combined with loss of motor power and sensation, great benefit will accrue from the steady use of nux vomica, strychnia, iron and quinine, with exercise in the open air, electricity, shampooing, the cold shower-bath, and the hot and cold douches.

SECT. II.—SPRAINS.

The spine is composed of a series of joints, which, from the peculiar mode of their connection, admit of comparatively little motion, except in the cervical and lumbar regions. The ligaments are, for the most part, very short and strong, and the column, as a whole, is still further strengthened by the large muscles and firm aponeuroses which cover them in at the sides behind. Owing to these circumstances, it is impossible for a sprain to occur here without the application of great force, either directly to the part itself or indirectly through some neighboring part, as when a person falls from a considerable height and alights upon the buttocks or shoulders. Now and then, a severe sprain of the back is produced by a sudden twist of the body, as when the trunk is forcibly rotated upon its axis, the lower extremities being at the moment implanted in a hole in the ground.

The extent of the injury varies. In some cases there is merely a stretching of the ligaments, whereas in others not only some of these structures, but also the muscles and aponeuroses of the back, are more or less contused, and, perhaps, even partially lacerated. In the more severe forms of the accident, such, for example, as happen when a man receives a blow from the caving in of a sand-bank, a portion of the spine may be bent forcibly forward or to one side, almost to such a degree as to cause it to break. More or less blood is then generally poured out, and the muscles often present a very bruised, ecchymosed appearance. Severe, however, as the sprain usually is, the spinal cord commonly escapes serious injury, the principal effect being concussion.

The symptoms of this accident are generally well marked, if not positively diagnostic. Not infrequently there is excessive shock attended with partial paralysis of the lower extremities. The pain at the seat of the injury is more or less violent, and is always materially augmented by motion, pressure, and change of posture. The patient cannot raise himself up without resting his hands firmly upon his knees, nor can he walk without being supported by assistants. During recumbency his body inclines forward, and he is unable to extend his limbs or turn upon his back. A good deal of swelling occasionally occurs, and, when there has been much extravasation of blood, the skin, after a few days, exhibits a dark, mottled appearance. Sometimes there is bloody urine, from injury inflicted upon the kidneys; and it has been remarked that, if these organs be previously diseased, hematuria may be produced by a very slight accident.

Sprains of the spine, if at all severe, are always serious accidents. Death may be produced by mere shock, as in concussion of the spine, or it may be a consequence of the secondary effects of the injury, such as a deep-seated abscess, inflammation of the cord and its coverings, or organic disease of the kidneys. Lesions of this kind are occasionally followed by stone in the bladder.

In the *treatment* of this class of injuries, the first indication is to relieve shock, and the second to prevent undue inflammation. Recumbency and the use of cordials generally readily fulfil the former; the lancet, leeches, fomentations, and active purgation, the latter. If the patient is plethoric, blood should be freely taken as

soon as reaction is established; the parts should be kept constantly covered with cloths wrung out of hot water, medicated with laudanum and acetate of lead; and Dover's powder, or morphia and tartar emetic, should be administered in full doses, to relieve pain and promote perspiration. If the suffering is excessive, a large blister may be applied, followed by the hypodermic use of morphia. After the severity of the injury is abated, the most suitable topical remedies will be sorbefacient and anodyne liniments, conjoined, if need be, with occasional dry cupping. When the patient is able to walk, benefit will accrue from the application of an opium plaster.

SECT. III.—WOUNDS.

Wounds of the spinal cord may be of various kinds, and are extremely apt, even when of small size, to eventuate fatally, from their liability to be followed by inflammation and softening of the proper nerve-substance. Copious hemorrhage sometimes attends them, still further complicating the case by inducing severe, if not irremediable, compression. Very terrible effects are also frequently caused when the accident is accompanied by fracture of the vertebræ, with depression of the bone, which is sometimes driven across the cord in such a manner as to divide it as completely as if it had been cut with a knife. At other times, small fragments of bone are buried in the substance of the cord. Paralysis, partial or complete, temporary or permanent, necessarily attends all lesions of this description. When the injury is very considerable, it may instantly destroy life, especially when it is situated above the origin of the phrenic nerves.

Gunshot wounds of the vertebræ, with lesion of the spinal cord, are nearly always, if not invariably, fatal. Of 22 cases of this kind in the English army in the Crimea, not one recovered. Even when the bones alone are injured, the danger is generally very imminent, most of the patients thus affected dying in a short time from inflammation of the cord and its membranes. When men fight behind trenches, terrible wounds, attended with excessive contusion and laceration of the muscles, are apt to be inflicted upon the back by shells, in consequence of the practice which they have, under such circumstances, of lying on the face while waiting for the explosion; such a position being regarded as the most safe. Of 157 severe cases of this description observed by the British surgeons in the Crimea, 20 died, 87 were sent to duty, and 50 were invalided. Dr. Otis has reported 187 cases of gunshot fractures of the vertebræ, which occurred during the late war in this country, all of which, except 7, proved fatal.

An excellent illustration of this class of injuries is afforded by a case of gunshot wound of the spinal cord, which I attended along with Dr. Thompson, in a gentleman, twenty-nine years of age, who was shot in the back with a pistol, the ball entering the left shoulder about two inches and a half below its top, and four inches and a half from the middle line. He instantly fell, and for a moment it was thought he was dead. It was ascertained, however, that he had merely sustained a violent shock; there was but little bleeding, and reaction soon followed. Intoxication existing at the time of the accident, it was impossible to make out a satisfactory diagnosis. The hands could be moved, but the lower extremities were completely powerless. The next morning, when the effects of the liquor had passed off, his body and legs were found to be completely paralyzed, and he was deprived of sensation from near the top of the sternum to the soles of the feet. The pulse was remarkably slow; the breathing heavy and laborious. The bowels were torpid, and the bladder had to be relieved with the catheter. The mind was clear and composed. These symptoms continued until he died, at the end of three days and a half. On dissection, it was discovered that the ball, lying loose in the spinal canal, had entered between the last cervical and first dorsal vertebræ, penetrating and pulpifying the cord, and cutting it in two by projecting across it a fragment from the injured bones. The annexed cut, fig. 103, from a specimen in the Museum at Washington, affords an illustration of a similar occurrence.

In another case, of which I have the particulars, but which I did not see, the ball entered near the right axilla, and, passing across the upper lobe of the corresponding lung, between the fourth and fifth ribs, cut the spinal cord in two, except a mere thread, and lodged in the body of the seventh dorsal vertebra. Immediate loss of motion and sensation ensued, and the patient, a man thirty years of age,

perished on the eighth day. The subjoined sketch, fig. 104, from a specimen in the Army Museum, at Washington, represents a knife wound, severing the spinal cord opposite the fifth dorsal vertebra.

Fig. 103.



Dorsal Vertebrae Fractured by a Conoidal Ball, which lodged in the Canal.

Fig. 104.



Knife Wound severing the Cord opposite the Fifth Dorsal Vertebra.

A case, kindly communicated to me by Dr. W. W. Keen, shows how much injury the spine may sustain without a fatal issue. The patient, a soldier, was wounded at the battle of Gettysburg by a ball which, entering the upper lip, lodged in the body of the third cervical vertebra, apparently, comminuting it completely. Altogether about sixteen pieces of bone were at various periods removed or discharged, one of them including the anterior half of the vertebral foramen. At first paralysis of all the extremities existed, but this rapidly subsided after the extraction of the ball, and the man, who subsequently reëntered the service, entirely recovered without any deformity of the neck, although nearly the entire body of the vertebra must have been destroyed.

In the treatment of wounds of the spinal cord, the great object should be to moderate inflammation, and to prevent effusion and other ill effects. If foreign matter be present, pressing upon the cord, it should, if possible, be removed, although in attempting to do this there may be great risk of increasing the original mischief. Trephining will not be likely to be of any service, the operation, which has been tried in a number of cases in depressed fracture of the vertebrae, seldom having been productive of the slightest benefit.

SECT. IV.—GENERAL EFFECTS OF INJURIES OF THE SPINE.

Although fractures and dislocations of the spine have already been treated of under separate heads, it will not be amiss, in view of the great importance of the subject, to reproduce here, in connection with the lesions above described, some of the leading phenomena by which they are characterized. These phenomena necessarily vary a good deal, according to the seat, nature, and gravity of the injury by which they are produced, and, for this reason, it is very important that they should be examined somewhat in detail. Such a course, in fact, is rendered the more necessary on account of the recent advances in our knowledge of the anatomy, physiology, and pathology of the spinal cord. The inquiry, to be of any practical value, must embrace almost every organ of the body.

1. The *mind*, in injuries of the spine, is variously affected, depending upon the presence or absence of complications. In the great majority of instances it is perfectly clear and intelligent, from first to last. In two cases, lately under my charge, of paralysis of all the extremities, caused by falls, the patients retained the full possession of their mental faculties up to the time of death, the one dying within the first four days, and the other near the end of the second week. When the lesion is seated high up in the cervical portion of the spine, the mind is more liable to suffer than when the dorsal and lumbar divisions are affected, and this is also the case when the concussion which so generally attends such accidents has extended to the brain. Coma, spasms, and even convulsions, may arise if the patient be seized with spinal, or cerebro-spinal, meningitis.

2. *Dyspnoea* is generally a distressing symptom, more especially when the lesion

is seated in the cervical, or cervico-dorsal, portion of the spine, from injury inflicted upon the the cervical and respiratory nerves. When the lesion exists above the fourth bone, death is generally instantaneous, from interruption of the breathing. When the dorsal and lumbar sections of the cord are affected, the embarrassment of respiration is usually due to paralysis of the abdominal muscles, and to the accumulation of gas in the bowels, interfering with the movements of the diaphragm. In the more severe forms of these accidents, the lungs soon become engorged with blood, and stuffed with mucus, speedily followed by asphyxia. When dyspnœa occurs long after the accident, or as a secondary affection, it is to be viewed as an effect of the disorganization of the spinal cord, consequent upon inflammation, softening, atrophy, or fatty degeneration.

3. The *vascular system*, as shown by the state of the heart, is variously affected. Generally the pulse is soft, but abnormally feeble and frequent, seldom, however, above eighty or ninety in the minute. When the dorso-cervical portion of the spine is implicated, great slowness of pulse is not uncommon, a condition obviously due to the direct impression made upon the nerves of the heart. The pulse always rises in frequency, and often, also, in force, when the cord becomes inflamed, softened, or disintegrated. When the thoracic ganglia and the sympathetic nerves are involved, as occasionally happens when the lesion is seated in the cervico-dorsal portion of the spine, there will be apt to be, as Bernard and Schiff have proved, unnatural vascularity of the pericardium, and serous effusion into the cavity of this membrane, but no appreciable lesion in the heart itself. In fatal cases the pulse always increases in frequency on the approach of death.

4. There is no regularity in regard to the nature or amount of involvement of the *digestive organs*, in injuries of the spine. Dysphagia may be present, when the lesion is seated high up, from paralysis of the œsophagus. Nausea and vomiting are uncommon. The appetite, generally impaired at first, often reinstates itself in a surprising degree during the progress of the case, especially in the milder forms of the accident. Tympanites and constipation attend nearly all injuries of the spine seated above the lumbar region. When the lumbar portion is involved, there is always, as a rule, loss of power in the sphincter muscles, with dribbling of urine, and involuntary fecal discharges.

5. The *urinary organs* never completely escape in any severe traumatic affections of the spine. Among the more common occurrences are, paralysis of the bladder, change in the quality and quantity of the urine, and inflammation of the mucous membrane of the bladder. These affections may be transient or permanent, in the one case lasting only for a few days, weeks, or months; in the latter, during the whole of the patient's life, whether that be short or long. Paralysis of the bladder may be produced instantly, as when there is a violent shock, laceration, contusion, or compression of the cord, or it may come on gradually, as when it depends upon secondary extravasation of blood. However this may be, there is always, as a consequence of this condition, retention of urine, demanding the use of the catheter. Sometimes, as when the lumbar portion of the spine has been injured along with the dorsal or dorso-cervical, retention coexists with incontinence from paralysis of the sphincter muscle of the bladder. The urine, in paralysis, soon assumes an alkaline character, and, undergoing rapid decomposition, becomes excessively acrid, irritating, fetid, of a dark color, and loaded with thick, ropy mucus, not unfrequently intermixed with pus and phosphate of lime. In rare cases it contains blood, albumen, or even sugar. Renal casts may be present when there is serious involvement of the kidneys. The quantity of urine is occasionally much increased, and cases have come under my observation, apparently of pure concussion, in which there was excessive irritability of the bladder, with frequent micturition. The urine, instead of being alkaline, may be acid, or alkalinity and acidity may alternate with one another. When the fluid is uncommonly acrid, it may provoke not only violent inflammation of the bladder, but even gangrene of the mucous membrane, the sloughs passing away in small, dark-colored shreds, of an almost insupportably fetid odor. Suppression of the renal secretion is uncommon.

6. Disorder of the *genital organs* manifests itself chiefly in the form of priapism. The affection, which is most common after injury of the cervical portion of the spine, or of this portion and of the cerebellum, generally supervenes within a short time of the accident, and, in the more severe cases, persists up to the moment of dissolution. The erections are seldom perfect, the penis being rather in a turgescent than in a

completely rigid condition, and they are usually, if not invariably, unaccompanied by voluptuous sensations. In chronic paralysis of the lower extremities, consequent upon injury of the spine, the sexual powers are sometimes very vigorous, the person being able not only to cohabit, but to produce offspring, as in the remarkable case reported by the late Dr. Childs, of New York, referred to under the head of fractures of the vertebræ.

7. *Motor paralysis* is an almost invariable occurrence in injuries of the spine attended with displacement of the vertebræ, or with wound, contusion, laceration, or compression of the cord. Its extent varies according to circumstances. In the great majority of instances, it presents itself in the form of paraplegia; but, when the lesion is seated high up in the spine, it may affect all the extremities, as well as the chest, abdomen, and pelvis. Sometimes it is limited to one limb, or to certain muscles. The sphincter muscles, as stated above, always suffer when the lesion involves the lumbar section of the spine. Motor paralysis is occasionally associated with muscular spasms, more especially when the lesion depends upon slight compression of the cord. Occurring late in the case, they are sometimes denotive of a return of motor power. In chronic paralysis the muscles become soft, wasted, flabby, and the seat of the fatty transformation.

8. *Anæsthesia* is a very common symptom; it usually exists by itself, but cases are met with in which it is associated with hyperæsthesia. The latter occasionally exists aside from motor paralysis, and is often attended with intense suffering, the more especially when it involves the entire body. When it exists in a very high degree, it is sometimes attended with a cyanosed condition of the skin, and great throbbing of the arteries.

Pain is a very common phenomenon; it is generally referred to the seat of the lesion, and not unfrequently coexists with hyperæsthesia. Considerable diversity obtains in regard to the nature and the degree of the pain. Thus, it may be slight or severe, sharp, scalding, burning, or accompanied with a sense of constriction, pricking, or tingling. These affections are generally most distressing when an important nervous trunk of an extremity is involved, when the burning or pricking feeling sometimes extends to the very ends of the fingers or toes.

9. Certain affections of the *eye*, as originally pointed out by Brodie, and since by Ogle, Brown-Séquard, Rendu, and others, are occasionally met with, chiefly, if not exclusively, in injuries of the cervical portion of the spine, involving the branches of the cervical and great sympathetic nerves, and manifesting themselves in contraction of the pupils, lachrymation, convergent strabismus, paralysis of the upper lid, and unnatural redness of the conjunctiva, accompanied with an increase of temperature of the neck and face, a flushed countenance, and more or less copious perspiration. In fractures and dislocations these phenomena are often directly chargeable to the presence of blood in the substance of the cord, intravertebral pressure, or disorganization of the nerve tissue from softening and inflammatory deposits.

10. A notable increase of vital *temperature* is not uncommon in these affections, coming on soon after the accident, and often continuing, with various alternations, up to the time of death. It is generally greatest in lesions of the upper portion of the cord, and is, probably, directly due to paralysis of the sympathetic, the great vaso-motor nerve. Varying in degree in different cases and in different conditions, it may be slight on the one hand, or very high on the other, as in the remarkable instance observed by Brodie, in which it amounted to 111°. It is occasionally associated with a most distressing sense of cold, particularly along the course of the spine and in the legs and feet, the patient feeling as if he would freeze. A persistent, elevated temperature is generally denotive of danger.

11. The *nutritive* functions are variously affected in these lesions. During the more acute stages, the body often becomes rapidly emaciated, the muscles are softened and attenuated, the fat is absorbed, and the skin is of a pale, sallow, almost icterode complexion. Great emaciation is frequently present even when there is no material disorder of the digestive organs, being evidently due to a want of proper assimilative power. The joints in the paralyzed limbs gradually stiffen, and in many cases are eventually completely ankylosed, the muscles and even the aponeuroses at the same time becoming permanently contracted, thus greatly augmenting the deformity and the local suffering. In chronic cases, the patient, instead of being emaciated, often increases in flesh, and, at times, is even remarkably fat.

12. *Bedsore*s are of common occurrence in traumatic lesions of the spine, no

matter what portion may be affected. The parts most liable to suffer are the structures over the prominence of the sacrum, the tuberosity of the ischium, and the great trochanter, as it is there that the greatest amount of pressure is experienced in protracted decubitus accompanied with inability of change of posture. The great trouble, in such a condition, is that the patient is generally entirely insensible, and, therefore, unconscious of his danger, until it has completely overtaken him. The first evidence of the local affection is a whitish, sodden condition of the skin, which soon assumes an ash-colored, brownish, or mottled appearance, and finally turns purplish or black, the slough, as it drops off, exposing a deep, foul cavity, soon followed by a copious, fetid discharge and excessive pain, often sadly aggravated by the contact of the urine and liquid fecal matter.

Diagnosis.—The diagnosis of traumatic lesions of the spine is generally very difficult; indeed, often impracticable, however carefully the parts may be examined. Sprains, fractures, dislocations, and wounds nearly always exhibit such striking similarities in regard to their phenomena as usually defy all attempts at a clear and satisfactory distinction. Even the symptoms of concussion not unfrequently closely simulate those that attend these accidents. With respect to the probable degree of injury sustained by the spinal cord, immediate, complete, and permanent paralysis is commonly denotive of the complete division of the cord, or of its compression by depressed bone, extravasated blood, or of both of these causes combined. In pure, uncomplicated concussion there may be loss of power, but it is usually only temporary. When the paralysis is gradual, or does not appear until a short time after the receipt of the injury, the presumption is that it has been caused by effusion of blood. When it does not make its appearance until after the occurrence of spinal meningitis, it may be assumed that it has been occasioned by inflammatory deposits. Paralysis of all the extremities is an evidence that the lesion is situated high up, above the origin of the brachial plexus of nerves; when the inferior alone are involved it implies that the mischief is located below this point. Excessive dyspnoea, flushed countenance, contraction of the pupils and convergent strabismus, are denotive of lesion of the cervical portion of the spine, complicated with disorder of the sympathetic and respiratory nerves. Tympanites, constipation, and retention of urine are always present in serious injury of the dorsal or dorso-lumbar portion of the spine. Incontinence of urine, as a primary affection, always exists in lesion of the lowermost portion of the cord. Priapism is generally a prominent phenomenon in injury of the superior portion of the spine, or of this division of the spine and of the brain.

Some variety occasionally arises in regard to the side on which the loss of motor power and sensation occurs, depending upon the nature and extent of the injury. In concussion the loss is nearly always symmetrical, although it may not exist in the same degree on each side. In wounds, on the contrary, as well, indeed, as in many cases of compression, whether caused by extravasation of blood or depression of bone, the effect may be unilateral, the paralysis and insensibility existing on one side, which may be either the sound or the injured, and instances are met in which there is loss of motion on one side and loss of sensation on the other. The extent of the loss of motion in these cases may generally be readily determined by the electrical test, which thus affords valuable diagnostic aid.

Dr. John Ashhurst has ascertained that more than one-half of the reported cases of spinal injury relate to the cervical region, upwards of one-fourth to the dorsal, and about one-tenth to the lumbar. Of 394 cases analyzed by him in 1867, 31 per cent. were dislocations, 49 per cent. fractures, and 13 per cent. a combination of fractures and dislocations. His investigations show that dislocations are most frequent in the cervical region, and fractures in the dorsal.

The diagnosis of the *secondary lesions* of the spine is not always so easily determined as might, at first sight, be supposed. The affections for which they are most liable to be mistaken are cerebral irritation, rheumatism, gout, and hysteria.

Cerebral irritation, consequent upon injuries of the head, comes on at a variable period after the primary affections, generally in a stealthy, insidious manner, and usually manifests itself in irritability of temper, loss of sleep, cephalalgia, disorder of the digestive organs, partial paralysis, excited pulse, and other indefinite phenomena, difficult, if not impossible, to be correctly interpreted. In some cases cerebral coexists with spinal irritation, more especially when the injury giving rise to it is seated in the cervical portion of the spine. When the spine alone suffers, the most trustworthy diagnostics are pain at some particular spot, increased by motion and

pressure, rigidity of the muscles of the back, tingling sensations in the extremities, impairment of motor power, and the absence of cephalic symptoms. When the cerebral and spinal symptoms are nearly equally balanced, a correct discrimination is usually impracticable.

The distinction between rheumatism and secondary traumatic affections of the spine is seldom difficult, the history, alone, of the case often sufficing to establish it. In rheumatism, the principal suffering is generally referred to the sacro-lumbar region; the attack comes on suddenly; the urine, scanty and high-colored, is loaded with lithates; and there is nearly always concomitant pain in other parts of the body, particularly in some of the joints. In gout, the patient complains of diffused pain and tenderness in the spine, along with pain in the limbs and hyperæsthesia; and during the existence of these phenomena gout usually occurs in the toes and fingers. In traumatic lesions of the spine the symptoms come on gradually, and progressively increase in severity; there is fixed pain with tenderness on pressure, usually corresponding with the seat of the original injury; prickling, tingling or burning sensations are experienced in the extremities; sensibility and motor power are gradually impaired; and the urine, although, perhaps, more or less acid, is measurably, if not entirely, free from lithates.

From hysteria the diagnosis will be sufficiently easy when it is remembered that the attacks in this affection are usually very sudden and more or less emotional, that they are almost peculiar to females, that they generally depend upon disorder of some important function, and, finally, that they are always characterized by distinct intermissions. In spinal disease, on the contrary, the symptoms, coming on slowly and almost imperceptibly, proceed from bad to worse, in a steady, persistent manner, and are gradually succeeded by loss of sensibility and motor power.

Prognosis.—Dyspnoea, flushed countenance, increase of temperature, priapism, and cerebral disturbance are unfavorable symptoms. The mortality is greatest in lesions affecting the cervical region, and least in the lumbar. Dr. Ashhurst finds that of the 394 cases of spinal injury, above adverted to, the mortality in the former region was 77 per cent., and in the latter 59 per cent. Two-thirds of the fatal cases of injury in the cervical region perished within the first week. In the other regions the fatal result generally occurred at a much later period. The causes of death are variable. Many of the cases die from shock, some from congestion of the lungs, if not from actual asphyxia; some from cerebral complications, and many from the secondary effects, as meningitis, disorder of the digestive apparatus, bedsores, and disease of the urinary bladder. When recovery takes place, the occurrence is generally denoted by a gradual return of sensibility and voluntary motion; some particular spot of the skin, or some special muscle, perhaps affording the first evidence of the fact.

Treatment.—The treatment of these lesions having already been discussed in connection with their respective characters, it only remains that I should insist here upon a few practical points, designed to promote the comfort of the patient, if not also his recovery. Of these, one of the most important is a good water-bed, with cushions and bolsters of a similar kind. The ordinary bed, even if provided with the best horsehair mattress, will be sure soon to cause sores and to become foul and offensive from the discharges. Special care should be taken to prevent undue pressure of the hips and the sacrum, frequent examinations being made to ascertain their condition, the more especially as the patient, from his insentient condition, is unconscious of what is going on. Unless the greatest vigilance be exercised, frightful bedsores, often more destructive than the primary affection, will be inevitable.

The bladder should receive prompt attention, the urine being drawn off regularly three times every twenty-four hours. The instrument, which should always be passed with great gentleness, should never be retained in the organ; first, because it might prove to be a source of mischief by its pressure upon the lining membrane, and, secondly, because it is very liable to be choked up with mucus, and to become incrustated with sabulous matter.

Great care must be taken in regard to the patient's posture. The respiration being generally much embarrassed, the diaphragm acts with difficulty, and, hence, any sudden change of posture, interfering with the breathing, might be followed by instant death. On no account must the patient be turned upon his abdomen.

In no class of affections is attention to cleanliness of more vital importance than in these. From the constant tendency of the urine and fecal matter to run over the thighs and nates, it is almost impossible, even with best directed efforts, to prevent

the formation of bedsores. Should such an occurrence unfortunately arise, every means calculated to ameliorate suffering should at once be employed, the general principles of management being regulated according to the rules laid down in the chapter on affections of the skin, in the first volume of the work. In addition to the means there suggested, trial may also be made, especially in the earlier stages of these complications, of galvanism, as originally recommended by Cruissel, and so successfully practised by Hammond, Wells, and other surgeons.

Pain must be relieved by anodynes; the diet must be light, concentrated, and nutritious; and every effort must be made to prevent meningitis, or, to moderate it, if it have already taken place. After the immediate effects of the injury have passed off, the great point is to promote the absorption of effused fluids by the employment of sorbefacient remedies, as iodide of potassium and bichloride of mercury, or calomel and opium, and frictions with dilute ointment of biniodide of mercury, soap liniment with iodine, and similar preparations. Neuralgic pains are generally most promptly relieved by veratria ointment. When the patient is very nervous, great comfort will accrue from the employment of the bromides, either alone or in union with chloral and oxide of cerium. Strychnia is of no use in traumatic lesions of the spine; and electricity seldom affords any material benefit. Trephining of the spine for the removal of depressed bone has been sufficiently discussed in the section on fractures of the vertebræ. Of the numerous cases in which it has been practised, that of Dr. Gordon, of Dublin, is the only one in which it was permanently successful.

SECT. V.—MENINGITIS AND MYELITIS.

The remark of Pott, that there is no injury of the head, however insignificant, that may not terminate fatally, is still more strikingly applicable to traumatic affections of the spine. How fully impressed the profession generally is in regard to the dangerous character of these lesions may be gathered from what was said upon the subject, many years ago, by one of the most acute observers and sagacious practitioners of the present century. "Every injury of the spine," says Abercrombie, "should be considered as deserving of minute attention;" adding, very justly, that the more immediate cause of anxiety in such cases is from inflammation, and from the insidious manner in which disease so often declares itself, perhaps under circumstances in which neither the patient nor his attendant anticipated any ill consequences.

Inflammation of the spine presents itself in two varieties of form; in one as a strictly meningeal affection, and in the other as an affection of the cord, respectively known as meningitis and myelitis. Not unfrequently, however, the two diseases coexist, commencing either simultaneously or nearly so; or, if the meninges are first involved, the morbid action, especially in cases that last for any length of time, eventually extends to the cord, or conversely. Meningitis and myelitis may be either acute or chronic, but, as the latter is simply a milder condition of the former, with an abatement, but no material differences in the character, of the symptoms, no special notice of it will here be necessary.

The starting point of acute meningitis is generally the pia mater, from which the disease rapidly spreads to the arachnoid membrane, and sometimes even to the dura mater, although the latter often escapes entirely. The attack usually comes on within the first eight-and-forty hours after the accident, being ushered in by a chill, which is soon followed by high fever, rapid pulse, and other evidences of constitutional involvement. Pain is an early and prominent symptom; it is felt most keenly at the seat of the inflammation, is increased by motion but not by pressure, and extends along the course of the nerves having their origin in the suffering portion of the cord. The muscles are variously affected; at first, there are merely spasmodic twitches; but these are soon succeeded by the most powerful contraction, especially of those of the back, causing great retraction of the head, and an arched, inflexible condition of the spine, not unlike what is witnessed in opisthotonos in the worst forms of tetanus. Sometimes the head is powerfully drawn to one side. The patient is unable to lie upon his back, and his limbs, exquisitely painful and partially paralyzed, are strongly flexed, voluntary extension being impossible. The breathing is hurried and embarrassed, the pulse is small but frequent, the eyes are intolerant of light, the countenance has a painful and contracted expression, the bowels are con-

stipated, and the bladder is unable to expel its contents. Hyperæsthesia is generally present in a distressing degree. When the disease is seated high up in the spine, there is nearly always, as was long ago observed by Ollivier, involvement of the membranes of the brain, thus greatly augmenting the suffering as well as the danger of the case. As the inflammation progresses, delirium, coma, and convulsions, preceded by complete paralysis of the extremities, especially of the inferior, ensue, death being caused either by asphyxia or exhaustion.

The most important symptoms of acute *myelitis*, at its commencement, are chilly feelings, more or less fever, and aching pains in the back and limbs, which rapidly increase in violence. Paralysis soon supervenes, often, indeed, in an almost incredibly short time, due apparently, in the first instance, to pressure of the cord by inflammatory effusions, and afterwards to the joint agency of inflammatory softening and deposits. Pain is always a prominent occurrence, usually most severe at the superior limit of the morbid action, and accompanied by a feeling of constriction, particularly distressing across the chest, as if a cord were drawn tightly around it. The state of the pulse varies; it is usually unnaturally frequent at the beginning of the disease, but after softening has taken place it becomes slow, soft and feeble. Anæsthesia generally exists in a notable degree, but, although this be true, the skin is often the seat of the most excruciating pain. Anomalous sensations of cold and heat are not uncommon; and there are few patients who are not annoyed by a feeling of numbness, formication, stinging, pricking, or tingling in different parts of the body, especially in the hands and fingers, the neck, chest, and face, the seat of these unpleasant symptoms being regulated by the seat of the inflammation. The thoracic, abdominal, and pelvic viscera suffer very much as in meningitis. When the cervico-dorsal region is involved, there will be more or less distress in the head, as pain, dizziness, vertigo, noises in the ears, and confusion of ideas with an early tendency to delirium.

The *diagnosis* of these two affections is generally very difficult, if, indeed, not impossible. In meningitis there is usually a greater degree of muscular contraction than in myelitis, while in myelitis, on the other hand, there is generally earlier paralysis, with greater frequency of the pulse. The pain on motion at the seat of the inflammation is more severe in the former than in the latter, and the flexion of the extremities is also more distinctly marked. In meningitis it is more common to meet with cerebral complications. Delirium often sets in early in the disease, whereas in myelitis the mind often continues clear until the last. Reflex action and muscular contractility remain unimpaired so long as there is no involvement of the cord. In myelitis there is usually a more distressing sense of constriction around the body than in meningitis; the urine is almost invariably alkaline; priapism is a very frequent occurrence; and there is a greater tendency to the formation of sloughs, from the pressure of the body, with a marked depression of temperature in the paralyzed limbs. The pain in myelitis is increased by percussion, and the application of a sponge wet with hot or cold water. In meningitis the pain is aggravated by motion but not by percussion or pressure.

Both these forms of spinal inflammation generally prove fatal, death occurring at a period varying from three to ten days. If a dissection be made, the pia mater will be found to be unnaturally vascular, the cephalo-spinal fluid greatly increased in quantity and more or less turbid from the intermixture of lymph, or lymph and blood, the arachnoid membrane opaque, and the meningo-rachidian veins distended with blood. Pus is seldom present, even in the more protracted cases. In chronic meningitis the dura mater is sometimes thickened and with great difficulty severed from its connections. When the inflammation is seated on the outside of this membrane, an abscess occasionally forms, the matter, if the patient survive any length of time, eventually discharging itself into the spinal canal, where it soon causes fatal irritation. In acute myelitis the most constant anatomical alterations are, unnatural vascularity and red or yellowish softening of the cord, not unfrequently amounting to actual pulpification of its substance, either central or peripheral, circumscribed or diffused. The vessels of the pia mater are turgid with blood, and the cephalo-spinal fluid is cloudy, flocculent, and augmented in quantity. In the chronic forms of these diseases, the arachnoid membrane is generally opaque, not uniformly but in spots of varying size and shape, some of which are very hard, thickened, and almost of a fibro-cartilaginous character. The cord, instead of being softened, is sclerosed, or one portion may be indurated and another softened.

In the *treatment* of these two affections the main reliance of the surgeon must be upon absolute rest; the application of leeches in large numbers to the seat of the inflammation; and the administration of mercury, in sustained doses, with a view to the speedy production of gentle but decided ptyalism. Pain must be mitigated, and sleep procured, by the free use of morphia. Diaphoretic anodynes, especially in the form of Dover's powder, must be used if there be deficient action in the skin. Blisters, applied in rapid succession to different portions of the spine, and hydrogogue cathartics, are particularly valuable in spinal meningitis, attended with serous or sero-albuminous effusion, after the disappearance of the more acute symptoms. In myelitis all remedial measures, except such as have a tendency to relieve pain and promote rest, are generally perfectly futile. In chronic spinal meningitis benefit occasionally arises from protracted, pyogenic counter-irritation, and the use of iodide of potassium in union with bichloride of mercury, five grains of the former with one-eighth of a grain of the latter constituting a reasonable average dose, repeated thrice in the twenty-four hours. The hot and cold douches, the cold shower-bath, electricity, frictions with the flesh brush, and inunctions of veratria ointment sometimes do good. Ergot and strychnia are, now and then, serviceable in imparting tone to the muscles, after the activity of the inflammation has been subdued. Great care must be taken to prevent the formation of bedsores, by the observance of cleanliness and the use of a water bed and other suitable appliances.

SECT. VI.—DEFORMITIES OF THE SPINE.

The spine is subject to various deviations, malformations, or deformities, known by the general appellation of curvatures. In order fully to comprehend the nature of these affections, it is necessary to recall to mind the fact that the vertebral column, in the normal state, consists of two pyramids, united at their bases, and that it presents, when viewed in profile, four distinct curves, all depending, except the lowermost, which is represented by the sacrum and coccyx, upon the different degrees of thickness of the bodies of the vertebræ and their fibro-cartilages in the different regions. Of these four curves, those of the neck and loins are concave behind, while those of the back and pelvis are convex, the reverse being the case when the column is viewed in front. This alternate arrangement of the curves is evidently designed for the more easy support of the superincumbent weight of the head and trunk; for, if the spine were perfectly straight, the vertical pressure would be much augmented, and it would, therefore, require a proportionately greater amount of strength to counterbalance it.

A slight degree of lateral deviation generally exists, in most cases even at a comparatively early age, on a level with the third, fourth, and fifth dorsal vertebræ, with the convexity on the right side, in consonance with a law of development that the growth and power of an organ are in the direct ratio of its exercise. Now, inasmuch as most persons naturally use the right hand more than the left, it follows that the muscles on the right side are larger and more vigorous than those on the opposite, and that, consequently, they have a constant tendency to drag the bones in question out of their normal position.

The abnormal deviations of the spine may be arranged under the three heads of lateral, posterior, and anterior, their relative frequency being in the order here stated. From this list I purposely exclude that form of curvature caused by tuberculosis, caries, or Pott's disease of the spine, and generally known as angular curvature. These several deformities may exist singly, as the only departure from the natural standard, or, as not unfrequently happens, they may occur in connection with each other. However this may be, they are all due, as was long ago correctly remarked by Cruveilhier, to the following causes:—"1. The wasting of the vertebræ by caries or softening. 2. Want of equilibrium between the strength of the vertebral column and the weight of the body, either alone or when oppressed by burdens. 3. Muscular traction. 4. The frequent repetition of any attitude in which the column is bent."

1. LATERAL CURVATURE.

In lateral curvature, the scoliosis of the older authors, the deviation of the spine is to one side, and is essentially due to irregular muscular contraction, acting upon

weakened bones, fibro-cartilages, and ligaments, and dragging them out of their natural position in such a manner as to induce more or less deformity. The side most commonly affected is the right, for the reason, probably, that most persons use the right arm much more than the left. Of 240 cases of lateral curvature, analyzed by Mr. Ward, of London, 230 were in this situation. I have myself seldom seen curvature on the left side as a primary disease.

The *causes* which give rise to this irregular action on the part of the muscles, enabling those of one side of the middle line to overpower those of the opposite side, and so establishing a tendency in the spine to deviate from the straight position towards the side of the stronger muscles, are of a diversified character, and possessing, as they do, important therapeutic relations, are deserving of attentive consideration. These causes may be conveniently arranged under the following heads:—1. Affections of the muscles, as hypertrophy, atrophy, inflammation, and spasmodic contraction. 2. Debility, either general or local. 3. Obliquity of the pelvis, from injury, disease, or malformation of the inferior extremities. 4. Altered capacity of one side of the chest, causing increased action of the muscles of the opposite side. 5. Rachitic softening of the bones. 6. Defective development of the vertebræ.

Hypertrophy of the muscles, as a cause of spinal curvature, may be induced in a variety of ways; often simply by excessive use of one arm, in the exercise of a particular avocation. Blacksmiths, compositors, tailors, seamstresses, and dragoons are remarkably prone to this form of spinal disease. It is a law of the animal economy that muscles grow and expand in proportion as they are exercised. Hence, if, for example, the muscles of one arm are more developed than those of the other, the necessary result will be a loss of equilibrium, on the principle that the stronger always overpower the weaker, and, therefore, just in proportion as this preponderance of action exists on one side will the spine, if the muscles so affected are attached to it, be drawn over towards that side. The muscles which are most liable to inordinate development from this cause, are the trapezius and rhomboid, which, acting directly upon the spine, completely overpower their fellows of the opposite side, causing thus a marked curvature, the convexity of which corresponds to the hypertrophied limb.

An effect similar to the above is sometimes produced when the muscles of one side of the spine become atrophied while those of the opposite side retain their healthy condition. The balance between them being thus destroyed, it is easy for the muscles which possess the preponderance of power so to act upon the vertebral column as to induce more or less lateral displacement.

Similar consequences ensue when the muscles become disabled by inflammation, as occasionally happens in rheumatism; or, by paralysis, as in severe contusions, and in failure of nervous influence; or, by spasmodic contraction, as in wry neck, which, whenever it exists in a high degree, is always accompanied by curvature of the cervical portion of the spine, occasionally in a very distressing degree.

Debility of the muscles is undoubtedly the most frequent cause of all. It may be general, or local; in the former case, affecting all the muscles, not only of the back, but of the rest of the body; in the latter, chiefly the spinal muscles. Anything that depresses the vital powers must necessarily weaken the muscular system, and lead to irregularity of action, disqualifying it for the due performance of its functions. Lateral curvature may often readily be traced to the debility occasioned by protracted fever and exhausting discharges. The patient, on recovering from his illness, finds that the muscles of the back are too feeble to sustain the spinal column in the erect position, and that, consequently, when he begins to walk, it is drawn towards one side, which is always in the direction of the muscles having the preponderating influence. Effects of a like character are produced by the use of unwholesome food, starvation, and inadequate clothing, eventuating in an impoverished and anemic state of the system.

Among the more common exciting causes of local debility, considered in its relation to spinal curvature, are, fatigue of the muscles of the back from the protracted maintenance of the erect posture, and arrested growth from tight lacing. The evil effects produced by sitting daily for a number of consecutive hours, without any support for the spine, are well exemplified in young ladies at fashionable boarding-schools, and in young female operatives in crowded factories. The erector muscles of the spine, being continually kept upon the stretch, soon become exhausted, and

by the constant repetition of the abuse are ultimately entirely disqualified for their task. If the child happens to be naturally feeble, or if she has become so by disease, the consequences of this practice are frequently most pernicious, the vertebral column being not only distorted laterally, but twisted more or less upon its axis.

The effects of tight lacing are known to every surgeon, not merely in their relation to spinal curvature, but in their influence upon the general health. There is not an organ of the body that is not injuriously affected by the corset, or that does not resent the "vile encroachment." Circulation, respiration, digestion, and secretion are all brought under its dominion. The muscles of the back are seriously restrained by it. Hence, if the practice be continued for any length of time, they must necessarily become stunted in their growth, and irregular in their action, unfitting them for the healthful discharge of their respective functions, those of the one side being rendered stronger than their fellows of the opposite side, and so dragging the spinal column out of place.

Obliquity of the pelvis is invariably followed, if long continued, by lateral distortion of the spine, particularly in the lumbar region. A good illustration of this coincidence is afforded in diseases and accidents of the hip-joint, in which, in order to throw the weight of the body upon the sound limb, the pelvis of the affected side is elevated, and a curve is formed in the loins, by the constant strain upon the spinal muscles. Affections of the knee-joint give rise to similar results.

The effect of an altered state of the chest in producing spinal curvature is well exemplified in what occurs in empyema and chronic pleurisy, where, in consequence of the compression and obliteration of the bronchial tubes, and the extensive morbid adhesions between the pulmonary and costal pleuræ, the ribs sink in and lie almost in contact with each other, thus greatly diminishing the capacity of the thorax of the affected side, while that of the opposite side is proportionately increased. The shoulder corresponding with the seat of the disease is notably depressed, and its muscles are so much weakened as to permit their fellows on the other side to draw the spine over in that direction.

Rachitis is a common cause of lateral curvature of the spine, the bones being so weak as to be incapable of withstanding the action of its several muscles. This disease, which is essentially of an inflammatory nature, and which is almost peculiar to early childhood, is characterized by great deficiency of earthy salts, rendering the osseous tissue so soft and flexible as to be easily cut and bent in almost any direction. The vertebral column, of course, participates in the morbid action, and it is, therefore, easy to perceive how it must be affected by the various muscles which naturally influence and control its movements. Some of the very worst examples of curvature that are met with are produced in this manner, the spine being drawn not only side-wards, but backwards.

Considerable lateral curvature of the spine is sometimes occasioned by an inequality in the length of the lower extremities, dependent upon disease, injury, or malformation.

Finally, lateral curvature may be caused by defective development or malformation of the vertebræ, some of the individual pieces being either too small or too large, or so united as to meet only at particular points instead of at their entire surface, as in the natural state. The consequence of this arrangement is that the muscles of the spine, intent upon regaining their equilibrium, soon act unequally, those of one side overpowering those of the opposite; not uniformly, but at different heights, so as to induce, perhaps, the very worst form of distortion.

The *extent* of the curvature produced by these different causes is variable. Thus, it may be limited to one particular region, or it may involve one-half, two-thirds, three-fourths, or even the entire length of the spine. When the affection is very extensive, the curvature presents itself in the form of an *Italic f*, compensating curves being formed on the opposite sides. In the more common cases of lateral curvature the deformity begins in the upper dorsal vertebræ, on the right side, in an abnormal development of the deltoid, spinatus, trapezius, and rhomboid muscles, which, overpowering their congeners of the opposite side, gradually drag the bones and everything that is connected with them over in the contrary direction, thus forming the first or middle curve of the series. The equilibrium between the muscles being thus destroyed, nature is not slow in her efforts at restoring it; but the only way in which she can accomplish this is by forming compensating curves, of which there are generally two, one in the lumbar region, and the other in the cervical, their develop-

ment usually occurring simultaneously, and, of course, in a direction opposite to the primary. There are instances, however, although they are rare, in which one continuous curve exists on one side, evidently depending upon paralysis of the muscles on the opposite side. A sigmoid curve can never rectify itself, and hence such cases are often irremediable, simply because it is impossible to establish a counterbalancing power in the congenerous muscles. The external characters of lateral curvature of the spine are well displayed in figs. 105 and 106.

Fig. 105.



Fig. 106.



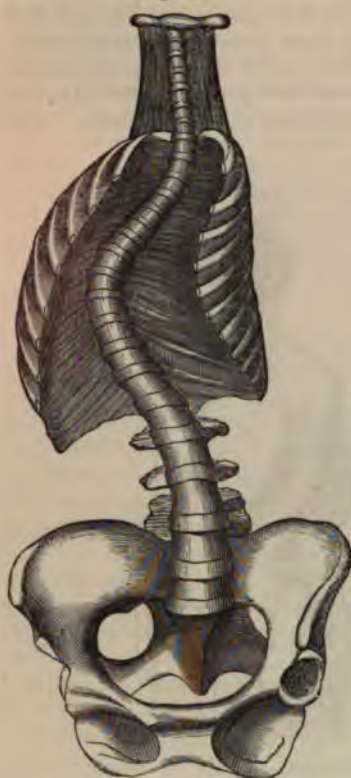
Different forms of Lateral Curvature of the Spine.

Lateral curvature, in its more aggravated states, is always attended with marked rotation of the spine, the rotation existing in the direction of the convexity of the curvature; the vertebral column is diminished in length in a degree proportionate to the lateral deviation, and the chest is materially altered in its figure, the ribs being flattened, elongated, and twisted, and the sternum and costal cartilages tilted prominently forwards, and depressed towards the pelvis. The scapula on the side corresponding to the convexity of the thoracic curve is unnaturally large and elevated; its upper border is directed forwards and inwards, while the inferior angle is carried outwards, and hangs off in a very unseemly manner from the side of the chest, in consequence either of the elongation of the latissimus muscle, or on account of the escape of the bone from beneath its surface. A lumbar curve always gives rise to obliquity of the pelvis, and a cervical one to obliquity of the head; so that there is occasionally, in reality, a quintuple curve. In the earlier stages of the affection, the curvature is formed chiefly at the expense of the intervertebral cartilages and ligaments; but, as it advances, the bones themselves become involved in the disorder, some portions being absorbed, and others strengthened by the addition of new osseous matter.

The annexed drawing, fig. 107, from a preparation in my collection, affords an excellent illustration of the vertebræ and ribs in the milder forms of lateral curvature.

The *symptoms* of lateral curvature of the spine are subject to considerable diversity, depending mainly upon the extent and duration of the lesion. In general, they are only such as are denotive of functional disturbance of the thoracic and abdominal viscera. In the milder cases, the patient experiences merely some degree of inconvenience in walking, becoming easily fatigued during exercise, and suffering from occasional palpitation of the heart, with, perhaps, some degree of uneasiness in breathing. Gradually, however, the general health begins to fail; progression, and the maintenance of the semierect posture, become more and more irksome; gastric and intestinal derangement supervene; the bowels are apt to be constipated; pains

Fig. 107.



Lateral Curvature of the Spine.

are complained of in the side and back; dysmenorrhœa is often present; and the countenance exhibits a pale, careworn, and chlorotic appearance, indicative of the crowded and compressed condition of the thoracic, abdominal, and pelvic organs.

Lateral curvature of the spine, to a slight degree, exists, as previously stated, in almost all persons on the right side, owing to the fact that nearly every one naturally uses the right arm more than the left. Hence, the corresponding muscles are always more developed, and, acting with more vigor than their congeners, usually draw the upper dorsal vertebræ a little over to the right; hardly, however, to an extent sufficient to deserve the name of disease. Considered as a morbid affection, it is most commonly observed in young girls, from the age of five to fifteen or eighteen, especially in such as are naturally of a feeble constitution, or whose health has become early impaired by want, exposure, and imperfect nutrition.

The *prognosis* of lateral curvature is generally favorable when the affection is recent, or of slight extent, in a person of comparatively healthy constitution. Proper management will then usually often effect complete restoration, although the treatment will require time and perseverance. Not unfrequently the mere rectification of a bad habit, causing an unnatural strain upon a particular set of muscles, will remove the complaint. When the affection depends upon extensive paralysis of the spinal muscles, organic disease of the vertebræ or of their cartilages and ligaments, or serious lesion of the pelvis, hip, or knee, great improvement may

be effected, but a complete cure will be difficult, and probably impracticable. The prognosis is also unfavorable in cases of long standing.

Treatment.—The treatment of lateral curvature must be governed, in great degree, by the nature of the exciting cause; hence, before any measures are instituted for its relief, the most careful inquiry should always be made with reference to this particular circumstance. So long as the cause under the influence of which the disease has been developed is permitted to continue in operation, it will obviously be impossible to make any favorable progress towards a cure.

The mere discontinuance, temporary or permanent, of a particular avocation will often speedily overcome the affection, by enabling the muscles of the two sides of the vertebral column to regain their equilibrium, upon the loss of which the trouble depends. Thus, the lateral curvature which results from hypertrophy of the muscles of the right shoulder and arm of the blacksmith, from a want of proportionate use of the other limb, may eventually be completely removed, if early attended to, before there is any structural change in the bones, cartilages, and ligaments, simply by transferring the hammer to the left hand. The steady, daily exercise of the left limb will soon bring out the full strength of its muscles, while those of the right arm, now comparatively quiet and inactive, will gradually be reduced in volume and force, and so in time permit a restoration of the balance of power, and, along with it, a return of the spine to the straight position.

Lateral curvature of the spine, contracted by girls at school and by children at factories, from a vicious habit of sitting, standing, or reclining, by which the vertebral muscles lose their equilibrium, can only be successfully cured by a reference to the nature of the exciting cause. The awkward and constrained position must be promptly rectified, and means adopted to improve the general health, when this has been suffering, by gentle exercise in the open air, sea-bathing, the cold shower-bath, and a properly regulated diet. Great attention must be paid to the gait in walking, so as to bring into full play the enfeebled and faulty muscles; the spine should be well supported while in the erect position by a light and well-adjusted brace; and

the child should be requested to lie down frequently during the day, in order to afford complete relaxation and rest to the entire system, so conducive to comfort and the restoration of vigor.

When the affection is manifestly dependent upon debility or want of tone in the general system, tonics will be indicated, and should be of such quality and given in such quantity as may be calculated to improve rapidly the condition of the blood and solids. The various chalybeate preparations, either alone or in union with quinine or tincture of bark, generally produce an excellent effect, and should be administered, steadily and persistently, for several successive months; the dose being occasionally varied, or a new article added, to relieve the monotony of the treatment. When marked emaciation exists, cod-liver oil will come in play, and will often rapidly improve both flesh and strength. The diet should be judiciously regulated; it should be perfectly plain and simple, but at the same time sufficiently nutritious in the smallest compass, so as not to crowd the stomach and bowels, or to interfere with the movements of the diaphragm and the expansion of the lungs. Fresh milk and sweet cream should be freely used, together with an allowance of brandy, wine, porter, or ale, suitable to the age and condition of the patient. Frequent ablutions with strong soap and water, or some alkaline solution, followed by dry friction, the occasional employment of the shower-bath, and gentle exercise in the open air, or, when this is impracticable, swinging in a hammock, the body being in a perfectly passive condition, will be valuable adjuvants. Shampooing the back, twice daily for thirty minutes at a time, is often of signal benefit in imparting tone and energy to the weakened muscles, and is deserving of more attention in this particular class of cases than it has hitherto received. When the muscles are exhausted by paralysis, the cold douche, the electric current, and gentle flagellation will prove useful, and may be employed conjointly with tonics and minute doses of strychnia.

Lateral curvature, depending upon obliquity of the pelvis, is not always curable, inasmuch as the cause itself does not invariably admit of removal. When this is the case, the weakened spine may be supported by appropriate stays, and by attention to the position of the body in progression, standing, sitting, and reclining. Similar means must be adopted when the fault lies in the chest, as in retrocession of its walls from empyema and pleuritic adhesions.

The treatment of rachitis, considered as a cause of spinal curvature, need not be particularly discussed here, inasmuch as it has received sufficient attention elsewhere. It is essentially an inflammatory affection, associated with, if not directly dependent upon, impaired nutritive action of the osseous tissue, attended with a deficiency of earthy matter, and consequent softening of the skeleton. The treatment must be alterant and tonic, and the spine must be mechanically supported until the bones have acquired a sufficient degree of solidity to enable them to resist effectually the influence of the muscles of the back.

When the affection is caused by inequality in the length of the two limbs, it may in general be readily rectified by inclining the body habitually to the opposite side, and by increasing the thickness of the sole of the shoe by the interposition of a narrow piece of cork.

Lateral curvature, dependent upon defective development of the vertebræ, requires early and persistent mechanical treatment, to sustain the weakened spine, and afford the affected parts an opportunity of being moulded into a more suitable shape for the due performance of their functions. The occurrence, which is, fortunately, very rare, is apt to be overlooked until it is too late to benefit the patient.

The treatment of lateral curvature, however induced, derives important aid, in almost every case, from mechanical support of the spine, and much ingenuity has been expended, especially of late years, in the invention of suitable apparatus, of which there is, consequently, a vast amount before the profession, all constructed upon the same principles, although possessing different degrees of merit. It may be stated, as a rule, that the more light, airy, and simple such apparatus is, the more comfortable it will be for the patient, and the better adapted to the removal of the distortion. It should consist of a steel framework, well cushioned to ward off pressure, and kept in place by straps and buckles. When there is considerable displacement of the cervical vertebræ, a head-piece may be added. The apparatus may be worn day and night; and, although it may at first prove irksome, such is the comfort derived from its use that the patient will soon be loth to be

Fig. 108.



Apparatus for the Correction of Lateral Curvature.

without it. The apparatus sketched in fig. 108 will afford a general idea of the principles upon which such a contrivance should be constructed.

The patient's bed should be furnished with a smooth and elastic mattress, in order that the body may not sink into any hollows or depressions, at the same time that it should be sufficiently soft to insure the requisite comfort. The object, however, of this arrangement is not to confine the sufferer to her bed beyond the hours which are necessary for a due supply of sleep and repose after exercise. In the antero-posterior displacement of the spine from caries, rest and recumbency, absolute and unconditional, are enforced, and scrupulously maintained for many months; here, on the contrary, rest and recumbency, although highly important, are not trusted to alone, but are carefully conjoined with gentle exercise in the open air, either on foot, in a carriage, or on horseback, as may be found most convenient or suitable to the patient. The body, in short, must be invigorated, and the faulty muscles set

in action by their appropriate stimulus, namely, motion, varied, diversified, and frequently repeated.

With out-door exercise is often advantageously combined a gentle course of gymnastics; but, to derive full benefit from it, it should be conducted under the immediate superintendence of a regular master of the art, well acquainted with the exigencies of the case; otherwise, immense harm instead of benefit will be likely to ensue.

Myotomy, as a remedy for the cure of this affection, is now seldom practised, experience having shown that it is generally entirely useless. The only cases to which it is at all applicable are those in which there is marked contraction of the muscles and aponeuroses of the spine, when it may occasionally be advantageously performed as an auxiliary to other measures.

2. POSTERIOR CURVATURE.

This variety of spinal deviation, fig. 109, sometimes described under the name of *excurvation*, *gibbosity*, or *cyphosis*—terms all more or less expressive of the nature of

Fig. 109.



Posterior Curvature of the Spine.

the deformity—is met with chiefly in young and elderly subjects, although it may take place at any period of life, as well as in both sexes, and in persons of every grade and occupation. The curvature, generally situated in the upper portion of the dorsal region, varies in degree from the slightest alteration of the natural form of the column to the most hideous deformity. When it exists in its maximum development, the body is literally doubled upon itself, the head and neck projecting almost at a right angle with the trunk. Such a degree of distortion, however, is very rare, except in very aged persons, and is very uncommon even in them. Cyphosis of the lumbar and cervical regions is infrequent. Occasionally an instance of general cyphosis is observed, the whole column presenting an arched appearance with marked concavity in front.

The causes of cyphosis, especially as it occurs in children and young persons, are essentially similar to those of scoliosis. Whatever has a tendency to weaken the

system, or to act injuriously upon the spine, may be regarded as establishing a predisposition to the disease. Among the more common and efficient of these causes are rapid growth of the body, imperfect assimilation, spanemia, syphilis, rheumatism, scrofula, softening of the osseous tissue, and the waste consequent upon protracted and exhausting maladies. Certain trades and occupations, requiring a stooping posture, belong to the same category. Whenever, from these or from any other agencies, the spine is materially weakened, the weight of the head and the irregular action of the muscles will readily draw the vertebræ out of their normal relations, and thus occasion a corresponding degree of distortion. Hence, posterior curvature is very common among tailors, shoemakers, engravers, scriveners, and persons of similar pursuits. The careless manner of leaning over books, and of sitting upon backless benches at school, with the shoulders and arms hanging forwards, is a frequent source of cyphosis. The deformity of the spine so often observed in old age is, apparently, a natural consequence of the "wear and tear" of the body, and is, therefore, hardly to be viewed as a disease.

The *pathological changes* in cyphosis vary, as in all other deviations of the spine, according to the nature of the exciting cause and the duration of the affection. When the disease is fully established, the bodies of the vertebræ, at the seat of the morbid action, will be found to be materially diminished in front, so as to impart to them a wedge-shaped appearance, while behind, where their nutrition is not impaired by the pressure, they retain their normal thickness, and are, sometimes, even partially hypertrophied. The intervening cartilages suffer in a similar manner. The spinous and transverse processes stand unnaturally apart, and the ligaments are more or less elongated. In protracted cases osseous bridges occasionally extend from the anterior surface of one vertebra to that of the other, and, now and then, the affected parts are completely ankylosed. All these changes are, as a rule, comparatively slight in young subjects and in ordinary cases of cyphosis.

Changes of a not less important character are observed in the chest and pelvis. When the gibbosity is seated in the dorsal region of the spine, the ribs are not only drawn back by the affected bones with which they are connected, but are rendered more prominent and angular behind, while their bodies, forced almost in contact with each other, gradually assume an elongated, rounded appearance: sometimes they are very much contorted, or twisted upon their axes. The sternum is remarkably prominent, and is either hollow or convex in front, according as it is bent at the sides or at the extremities. The shoulder-blades hang off from the trunk in an awkward, unseemly manner, being greatly depressed anteriorly, and very salient behind, where they almost approach the spine. In cyphosis of the loins, the pelvis is often sadly distorted; it loses its obliquity in front, and assumes almost a horizontal direction. When the distortion is very low down, the sacro-vertebral angle is sometimes nearly entirely effaced. Finally, the muscles of the back, elongated and inactive, are pale, wasted, flabby, and partially transformed into fatty matter.

The *symptoms* of cyphosis are not doubtful. A careful examination, made while the patient is divested of his clothing, will generally at a glance detect the characteristic deformity. The gibbosity will be more or less marked, according to the nature of the exciting cause and the duration of the case, but is never as abrupt or distinctly defined as in angular curvature dependent upon Pott's disease. It is, as before stated, usually most conspicuous in the upper part of the back, or in this situation and in the lower cervical region, and seldom involves less than from three to five of the vertebræ. In the more aggravated forms of the affection, the head is sunk down, as it were, between the shoulders, which are themselves more or less deformed and displaced; the arms hang awkwardly along the sides; the chest, elongated in the antero-posterior diameter, and diminished in the transverse, is narrowed in front, and expanded behind; the abdominal muscles are contracted; and the distance between the ensiform cartilage and the pubic symphysis is sensibly lessened. In cyphosis of the neck, the head inclines forwards, and the chin almost approaches the sternum, thus imparting a singular expression to the physiognomy.

Long before the changes now described are fully formed, evidence, more or less well-marked, usually exists of the mischief that is going on in the spine. The general health is commonly found to be at fault; the patient is weak and unable to bear his accustomed exercise; the countenance is pallid; digestion is impaired; the bowels are irregular and distended with gas; the appetite is vitiated; there are frequent acid eructations; the urine is high-colored, and often alkaline; the sleep is disturbed

and unrefreshing; the extremities are habitually cold; and various kinds of pains, with more or less tenderness on pressure, are felt along the course of the spine. Gradually the symptoms grow worse; exercise is either impracticable, or tolerable only at long intervals and in a slight degree; the erect posture is maintained with difficulty; and the patient becomes eventually frightfully stoop-shouldered. When the disease is fully established, the deformity of the spine and chest existing in the worst degree, the functions of the heart, lungs, and abdominal viscera will be more or less seriously disturbed, from the compression to which they are subjected by the walls of their respective cavities.

The *prognosis* of cyphosis varies with so many circumstances, general and local, as to render precision of statement entirely impracticable. The senile form of the complaint is, of course, irremediable, while that of the earlier periods of life is usually, under proper management, perfectly amenable to treatment, and is often recovered from without any appreciable deformity. The result must, necessarily, in every case, be materially influenced by the nature of the exciting cause, by the duration of the complaint, and by the changes that may have taken place in the bony frame-work of the spine, chest, and pelvis.

Treatment.—In the treatment of this affection, three leading indications must steadily be kept in view: 1st. The removal of the exciting cause; 2dly, the amendment of the general health; and 3dly, the proper support of the weakened spine.

The first indication is fulfilled by the rectification of any diathesis, as the strumous, syphilitic, or rheumatic, that may exist, by the restoration of suppressed secretions, by change of air, exercise, and food, and by the correction of any vicious habit, calculated to perpetuate the morbid action.

The general health is nearly always more or less deranged, and it will, therefore, be found that most of the subjects of this disease will be materially benefited by a course of chalybeate tonics, quinine, or extract of bark, mild laxatives, as blue mass and rhubarb, diuretics, sea-bathing, or a residence near the seashore, alcoholic stimulants, and a concentrated, nutritious diet. Dry frictions with the salt towel will be advantageous. Exercise should daily be taken in the open air, in pleasant weather, but never carried to fatigue. The patient, when in the house, should recline much of the time upon his lounge, being particularly careful to avoid everything like a strain upon the muscles of the spine.

Of the various mechanical supporters that have been devised for the relief of cyphosis, one of the very best is that delineated in the section on tuberculosis, inasmuch as it fulfils admirably all the indications for which such an apparatus can be applied. The most important elements in any contrivance of this kind are, lightness and strength, accurate adaptation to the surface of the body, and concentration of pressure at the seat of curvature. The pressure must be regulated with the greatest care, and should be as gentle as is consistent with the requisite degree of support. The surface of the lounge or bed upon which the patient rests should be soft, elastic, and uniform. No pillow should be used. The posture may be varied from time to time, from the back to the side, or from the side to the abdomen, as may be most agreeable.

3. ANTERIOR CURVATURE.

In this affection, the lordosis of the older surgeons, the curvature is directed forwards, either as an exaggeration of the normal condition, or as a result of disease. As compared with the other distortions of the spine, it is exceedingly infrequent, and is generally limited to the loins or dorso-lumbar region. It is very rare in the neck, and still more uncommon in the upper part of the back. Duverney has recorded an instance in which the curvature existed in the back, loins, and sacrum, the intervertebral cartilages being ossified, and the spine almost completely ankylosed. When the lordosis is confined to the dorsal vertebræ, a very unusual occurrence, there is always great deformity of the chest. In an interesting case, observed by Delpech, the position of the sternum, ribs, and costal cartilages was so completely changed that the thorax looked more like a vertical box than a portion of the natural skeleton. The characteristic features of the more common form of lordosis are well illustrated in fig. 110, from a clinical case. Lordosis is most frequent in children and young persons, and is usually dependent upon disease of the pelvis, the hip-joint, the vertebræ themselves, or of the skeleton generally. In fact, the curvature

is, in most cases, simply a compensatory one, formed during the progress of other affections, and designed as a means of preserving the equilibrium of the head and trunk. It has occasionally been noticed as a congenital vice, and is one of the ordinary concomitants of ovarian dropsy, coxalgia, unreduced dislocations of the hip-joint, psoas abscess, rachitic softening of the bones, and Pott's disease of the spine. Temporary lordosis always exists, to a greater or less extent, during the latter months of pregnancy. I have met with several cases of lordosis of the dorso-lumbar region in very young children, as a consequence, apparently, of a rheumatic and contracted condition of the muscles of the loins. The annexed sketch was taken from a little girl, only three years of age, perfectly healthy, and well-formed in every other respect.

When lordosis is caused by rachitis, coxalgia, dislocation of the hip-joint, or Pott's disease, it is generally, indeed almost invariably, associated with lateral curvature, on the principle that such an arrangement is most conducive to the preservation of the equilibrium of the body.

The *pathological changes* in this affection have not, in consequence of the great rarity of lordosis, been well determined. In the earlier stages, and in the milder forms of the disease, if so it may be considered, it seldom happens that there are any appreciable lesions. In the older and more confirmed cases, the bodies of the vertebræ are generally more or less indurated behind, if not throughout their entire extent; the intervertebral cartilages are partially absorbed, if not ossified; and the motions of the joints are either much impaired or completely annihilated. The muscles of the back are abnormally rigid, wasted, and otherwise altered. Very generally they undergo the fatty degeneration.

The *effects* of incurvation of the spine vary according to the seat of the affection. In lordosis of the loins the principal distortion is in the pelvis, consisting in a remarkable obliquity of its horizontal axis. The pubic and iliac bones are strongly depressed, while the sacrum and ischiatic bones are proportionately elevated. The bodies of the vertebræ are widely separated in front, and closely approximated behind; the spinous processes are almost in contact with each other, and, consequently, much less salient than in the natural state. The abdomen is exceedingly protuberant, the hips stand out in bold relief, the shoulders are retracted, and the head is inclined forwards. The gait and appearance resemble those of a pregnant female, or of a person affected with ovarian dropsy.

In lordosis of the cervical region, the head is drawn backwards, so as to form with the shoulders a deep hollow; the face is turned almost directly upwards; the neck is elongated anteriorly, and the larynx is uncommonly prominent. The motions of the joints are greatly impaired, and, in cases of long standing, there is sometimes complete ankylosis.

When the dorsal region is the part more particularly involved, there will be, as before stated, more or less serious deformity of the chest, disordered circulation, embarrassment of respiration, cough, bronchitis, and even considerable engorgement of the lungs, from the habitual compression of the thoracic viscera.

The *prognosis* of lordosis is favorable when the affection has been induced by rheumatism, by vicious habit, or by pregnancy. No cure can be effected when it depends upon a rachitic condition of the bones of the inferior extremities, coxalgia, disease of the pelvic bones, caries of the spine, or an unreducible dislocation of the hip-joint. Indeed, under such circumstances, as the curvature is a compensatory one, a cure would not be desirable, as it would destroy the equilibrium of the head and trunk, and thus cause a much more serious deformity than the one it was designed to remedy.

Treatment.—The treatment of this variety of spinal distortion must be conducted upon the same principles as that of posterior curvature. The pressure must be made to bear more particularly upon the abdomen and the lower portion of the chest in front, and upon the back and pelvis behind. A piece of gum-elastic webbing

Fig. 110.



Anterior Curvature of the Spine.

Fig. 111.



Apparatus for the relief of Anterior Curvature.

will be found of great service in equalizing the compression of the abdomen, a matter of no little moment in regard to the comfort of the patient, as well as to his ultimate recovery. When the curvature involves the cervical region, proper attention must be given to the support of the head. A very suitable apparatus for the more ordinary forms of lordosis is sketched in fig. 111.

The general health must not be neglected. Most patients will be benefited by the use of tonics, the cool or cold shower-bath, frictions with the dry salt towel, change of air, and an occasional laxative. The nature of the exciting cause should always be steadily kept in view in prescribing for such cases. Exercise will be of great service, but it should not be carried to fatigue, and much time should be spent, in the intervals of taking it, in recumbency. In the rheumatic form of the affection, Dover's powder, wine of colchicum, and anodyne liniments will be found to be among the best remedies. For symptomatic or compensating lordosis treatment affords no permanent advantage.

4. ANGULAR CURVATURE, TUBERCULOSIS, CARIES, OR POTT'S DISEASE.

The bodies of the vertebræ, composed, in great measure, of areolar tissue, invested by a thin layer of compact substance, are liable to tubercular deposits, similar to those that are so frequently met with in the carpal and tarsal bones, and in the articular extremities of the long bones. The affection, from its destructive character, is one of very grave import, and has, therefore, always engaged the earnest attention of surgeons. It has been, however, only within a comparatively recent period that its true nature has been properly understood. It was reserved for Mr. Pott, towards the latter part of the last century, by a series of masterly observations and dissections, to point out its etiology, pathology, and treatment, and so completely did he exhaust the subject that nothing of any real importance has been added to our knowledge of it since his death. Indeed, so graphic is his account of the disease that it is now generally known by his name.

Although the affection may occur in any portion of the spine, it is much more common in the dorsal region than in either the cervical or lumbar, the second, third, and fourth pieces being especially prone to suffer. It is generally asserted that the lumbar vertebræ are more frequently affected than the cervical, but this I have not found to be the case in my own practice. Why caries of the vertebræ should be so much more common in the dorsal region of the spine than elsewhere, it is impossible to determine; but such is unquestionably the fact, and the circumstance is one of great importance, both in a diagnostic and practical point of view.

Pott's disease occurs in both sexes, in all classes of society, and at different periods of life, although it is much more common in children from the age of three to twelve years than at any other time. I have met with it as early as the ninth month, and cases are occasionally observed as late as the thirtieth or even the thirty-fifth year. It is most common in the lower walks of life, among the ill-fed and half-starved occupants of the crowded lanes and alleys of large cities, and always recognizes, as its essential cause, a strumous state of the system. Like tubercular disease of the lungs, it is, in fact, merely a local manifestation of a constitutional vice, or a general dyscrasia of the blood and of the solids. This, therefore, constitutes its great and fundamental principle; the indispensable condition of the system which precedes the outbreak of the local affection. External injury, exposure to cold, and various other depressing influences may excite the disorder, but no such occurrence could possibly arise either from these or any similar causes, if a strong tendency to the disease did not exist in the constitution at the time of their application.

The tubercular matter, the immediate cause of caries of the spine, is deposited in the areolar structure of the bodies of the vertebræ, either as an infiltration, or in the form of distinct, rounded masses, from the size of a millet seed to that of a pea, a few of which are sometimes encysted. It is not improbable that more or less is also occasionally deposited upon the surface of these bones, beneath the periosteum, in the substance of the periosteum, or in the interior of the intervertebral cartilages, or per-

haps in all of these situations simultaneously or successively. How long it exists before it becomes softened and disintegrated, is not ascertained; the period, doubtless, varies in different cases and in different conditions, but, on an average, it probably does not exceed five or six months, the substance obeying the same laws here as in other parts of the body. Be this as it may, when the process has once fairly commenced it generally proceeds very rapidly, so that it often produces very serious havoc in the course of four or five weeks, completely annihilating the affected structures, and causing great and irremediable deformity. If a dissection be made at this stage of the disease, a gap, fig. 112, the size of which corresponds with the number

Fig. 112.



Caries of the Vertebrae; the Bodies being extensively destroyed.

Fig. 113.



Angular Curvature from Caries

of vertebrae affected, will be found to exist in front of the spine, occupied by unhealthy stromous matter, the debris of disintegrated bone, fragments of fibro-cartilage, and thickened periosteum. The spinal cord and the roots of the spinal nerves will be observed to be more or less denuded, and the remnants of the diseased vertebrae to be thrust backwards in such a manner as to cause an antero-posterior curvature, very marked behind, in consequence of the unnatural projection of the spinous processes, as in fig. 113. When the lesion is seated in the dorsal region, the adjoining ribs often participate in its ruinous effects, and the matter is sometimes extensively diffused over their internal surface, as well as over the anterior and lateral aspect of the spinal column.

The number of vertebrae involved in this disease is variable; sometimes it is limited to a single piece, but most generally it attacks two or three, the spongy substance of which, together with the intervening fibro-cartilages and the contiguous periosteum, is eventually completely destroyed.

Symptoms.—The affection usually comes on in a slow and stealthy manner; hence, it often makes very serious inroads both upon the part and system, before its true character is even suspected. Among the earlier symptoms is an appearance of gradually declining health; the child looks pale and feeble; the appetite and bowels are irregular; the gait is vacillating, tottering, and denotive of irritation of the spinal cord; the strength is easily affected by exercise; the lower extremities are cold and numb, and the seat of spasmodic twitching; the respiration is short and hurried; the abdomen is tumid and flatulent; pain, generally recurring paroxysmally, and resembling gastro-enteralgia, is complained of, if the patient is sufficiently old to express his feelings; the urine is alkaliescent, pale, scanty, and often retained with difficulty; the sleep is disturbed by dreams and moans; the mind is peevish and fretful; and there is frequently a good deal of fever at night, followed, perhaps, by considerable perspiration towards morning. By and by, the symptoms assume a more decided character. Pain and tenderness are now perceived in the back, and percussion of the affected part generally causes a peculiar sickening sensation; a feeling of constriction is experienced in the chest, as if it were girded by a tight

cord; the difficulty of walking rapidly augments; the erect posture is no longer practicable; every movement is performed with the greatest care, lest some sudden jolt of the body or concussion of the spine should augment the suffering; the legs and feet are not only more numb than before but the seat of a disagreeable, prickling sensation, evidently caused by the pressure of the diseased bones upon the contents of the vertebral canal; paralysis gradually supervenes; the general debility progressively augments; and everything denotes the downward tendency of the case. The paralysis exists in various degrees; in some cases, it is extremely slight; in others, so great as to deprive the patient completely of the power of progression. When the disease involves the cervico-dorsal region, and is of very limited extent, the paralysis may be confined exclusively to one arm, or, if both limbs are affected, one suffers more than the other. Motion is usually impaired before sensation;

indeed, the latter often remains intact, or nearly natural, when the other is wholly destroyed. The adjoining cut, fig. 114, beautifully exemplifies the effects of the compression which the spinal cord sometimes experiences in posterior curvature.

Fig. 114.



Section of a Spinal Cord in a case of Paraplegia, with angular Curvature of the Vertebræ.

The *deformity* of the spine is always characteristic; it is angular backwards, as in fig. 115, or backwards and more or less to one side, and varies in extent according to the number of vertebræ affected, and the duration of the disease. It is limited to the seat of the disease, and is generally associated with a kind of knob-like enlargement of the neighboring parts, especially conspicuous when there is serious involvement of the ribs. The parts at the seat of this enlargement are hard and usually very tender on pressure. The swelling often extends several inches around the primary disease, and is always very distinct when the case has made considerable progress, whether it be viewed from behind, or sideways. In the more aggravated cases, the spine is bent back many inches beyond its natural level, the chest is singularly elongated in the anterior posterior direction, the sternum is pushed out in front, and the head is

sunk down between the shoulders, causing that peculiar hump-backed appearance which forms so striking a feature in the symptomatology of this disease in its confirmed stages. If the body be viewed in profile, the chest will be found to represent

Fig. 115.



Fig. 116.



Angular Curvature of the Spine.

the outline of a triangle, the apex corresponding with the affected part, and the base with the sternum and costal cartilages. These appearances are well represented in fig. 116, from a preparation in the Mütter collection.

The matter which forms in this disease may be absorbed, leaving, perhaps, merely some of its more solid portions, in a dryish, indurated condition; or it may accumulate, and ultimately seek an outlet, either through the back near the seat of the disease, or it may gravitate along the front and sides of the spine, as in fig. 117, and eventually point in the groin, the lumbar region, or the upper part of the thigh.

Diagnosis.—The diagnosis of this disease, although in general very easy, requires some care, especially in the incipient stages of the attack. No one can mistake it after the occurrence of excoriation. The affections with which it is most liable to be confounded are sprains, rheumatism, neuralgia, hysteria, and spinal abscess.

The most reliable circumstances, diagnostically viewed, are the age of the patient, the existence of abdominal or of abdominal and thoracic pain, and the peculiarity of the gait. There are other points of less importance but still deserving of serious consideration.

1. Tuberculosis of the vertebræ usually occurs before the tenth year, and is almost invariably associated with the strumous diathesis, often directly traceable to one of the parents, or indirectly to some collateral member of the family. The disease commonly arises without any assignable cause.

2. Pain in the abdomen or in the abdomen and chest is generally an early symptom, which nearly always precedes by several months the occurrence of pain in the spine at the seat of the disease. It is not constant but paroxysmal, is often exceedingly severe, and is usually referred to the stomach, the ensiform cartilage, or the epigastrium, from which it is liable to radiate in different directions. It is frequently, if, indeed, not generally, strictly neuralgic in its character. Fatigue, exposure to cold, indigestion, the use of improper food, or any sudden and unguarded movement, twist, jolt, or concussion of the body, trunk, neck, or spine is sure to aggravate it. Owing to the tender age of the patient, this symptom is often ill-expressed, and, therefore, of little diagnostic value.

3. A notable feature in the early stage of the disease is the inability to hold the trunk erect. The body, during progression, is bent forwards and the head backwards, the shoulders are unusually protuberant, the arms hang awkwardly along the sides with the elbows behind the line of the back, the feet are unnaturally separated, with the toes inclined more or less inwards, and every step is slow and measured, as if the child were afraid to hurt himself. In fact, the general attitude is expressive of pain and suffering, and is of itself almost characteristic of the nature of the malady. As the case advances, the trouble of progression steadily augments; the trunk is inclined forwards more and more; and the patient is unable to walk without supporting himself with his arms upon his thighs. He hardly lifts his feet, and is prone to trip and fall. He finds it difficult to rise off his chair, to pick up anything upon the floor, to elevate his arms, to turn around in bed, or to twist his neck and trunk. The slightest motion, in fact, is a source of pain and suffering. Exercise, however gentle, soon fatigues, and he instinctively seeks relief in recumbency.

4. Numbness and prickling sensations are often complained of at an early period, and, therefore, possess, in many cases, a very decided diagnostic value.

5. The respiration is short, frequent, sometimes almost panting, especially during exercise, and performed with gradually increasing difficulty; occasionally, with a peculiar catch.

6. The temper is easily ruffled. The child is peevish, fretful, despondent. The sleep is interrupted by gastro-enteric pains, by disagreeable dreams, and by spasm and twitching of the feet and legs.

7. The action of the heart is more or less disturbed even at an early period of the disease. It is irregular, frequent, quick, and irritable, especially in the more advanced stages; after the occurrence of deformity, it is generally loud and tumultuous.

8. Pain in the back is seldom an early symptom; nor in any stage of the complaint a very reliable one; for, in the first place, it does not by any means always clearly indicate the existence of organic disease either of the vertebræ, of the spinal cord, or

Fig. 117.



Abscess of the Spine from Caries of the Vertebræ, the Cyst in which the matter is confined being interposed between the Bone and the Aorta.

of its membranes; and, secondly, it is well known that these structures may be seriously involved, and yet not occasion any pain whatever. Nevertheless, pain in the back, especially if circumscribed and persistent, should always be regarded with suspicion, and provoke the most diligent inquiry into the nature of the disorder. The cases are not at all uncommon in which the very first appreciable evidence of tuberculosis is the projection of the spinous process of one of the vertebræ, without any apparent antecedent disturbance of the general health, or the utterance of any decided complaint by the child. In the more confirmed stages of the disease, pain in the back, or back, chest, and abdomen, is often, if, indeed, not generally, a prominent symptom, especially when there is involvement of the contents of the spinal canal; it is of a dull, heavy, aching, or gnawing nature, and is invariably aggravated by pressure, exercise, motion, or any sudden twist of the body. The patient, if old enough, frequently describes it as being of a faint, sickening nature.

9. Paralysis may appear early, but in general it does not come on until the osseous disorganization has committed serious ravages, involving the spinal cord and its envelops. A sense of formication, numbness, or prickling, with progressive loss of muscular power, should always be regarded with anxiety, as it may lead to the detection of the disease before the occurrence of marked deformity of the vertebræ.

10. Constriction of the chest and embarrassment of breathing are invariable symptoms when the disease is situated in the dorsal vertebræ, especially the superior. When the cervical vertebræ are implicated, the patient finds it difficult to support his head, and may even have paralysis of one or both arms. Indigestion, flatulence, and constipation of the bowels attend when the disease affects the lower dorsal vertebræ; and in tuberculosis of the lumbar portion of the spine there is, generally, in addition to the abdominal disorders, disturbance of the bladder, as difficulty in retaining or voiding the urine, and an alkaline condition of this fluid.

11. Finally, as the disease progresses, the strumous cachexy is rendered more and more conspicuous; the countenance is pale and wan; the blood is impoverished, and reduced in quantity; the appetite and strength decline; and life is gradually worn out by hectic irritation.

The symptoms of this disease are sometimes painfully simulated by a sprain of the back; and, when this is the case, the diagnosis can only be determined by a most thorough examination of its history.

Rheumatism and neuralgia of the spine are very uncommon in children, and, when they do occur here, they are generally associated with similar attacks in other parts of the body.

The distinction between hysteria and this affection is sufficiently broad. The former seldom occurs until after the age of puberty, whereas the latter is nearly always met with prior to that period. Hysteria is most common in females, and is generally associated with disordered menstruation.

Abscess of the vertebræ is seldom seen at an age when tuberculosis of the spine occurs. Besides, the matter rarely points in the situation of Pott's disease, unless it forms as a consequence of it. A psoas abscess, as it is termed, usually points just above Poupart's ligament, at the upper part of the thigh, or in the ilio-lumbar region.

An aneurism of the chest or abdomen may simulate Pott's disease of the spine. The pressure of the tumor may gradually destroy the bodies of the vertebræ, and thus cause great pain and tenderness of the affected region, with a tendency to posterior curvature; symptoms difficult, if not impossible, to be distinguished from those attending tuberculosis.

The history of the case often supplies important light. The subjects of Pott's disease are, as before stated, commonly very young children, of a puny, sickly, anemic character, with light hair, eyes, and complexion, a tumid belly, and cold extremities, with a tendency to cutaneous eruptions and strumous affections in other parts of the body.

In all cases of suspected disease of the vertebræ a most thorough examination should be made until all doubt about its true nature is cleared up. For this purpose the patient should be completely stripped, and made to walk back and forth, with a view of observing his gait, or the manner in which he holds and lifts himself. He should then be placed upon his abdomen, and pressed carefully with the thumb along the spine, in its entire length. If there is any disease it will be sure to manifest itself by the pain, tenderness, or sickening sensation that will thus be awakened.

If, notwithstanding this, any doubt exists in regard to the nature of the affection, the patient should be treated precisely as if it were scrofulous disease, otherwise precious time may be lost under the supposition that the malady is rheumatism, neuralgia, or hysteria.

Prognosis.—A disease which makes such sad inroads upon the part and system as this is necessarily a grave disorder under any circumstances; but when it occurs, as it generally does, in children of a broken-down, miserable constitution, ill-fed and half-naked, or whose bodies are completely overwhelmed by the strumous diathesis, the prospect of an ultimate cure must be very limited indeed. Many such patients perish from hectic irritation, while the majority of those who recover are doomed to a wretched existence, permanently dwarfed and hump-backed. In the better class of subjects restoration is the rule, death the exception; and it is well to know that, if the case be properly managed, excellent cures, with little or no deformity, may be made even when the disorder has already produced considerable structural change.

When the disease is located in the cervical region, the prognosis is generally less favorable than when it affects the dorsal or lumbar; yet very extraordinary recoveries are now and then witnessed, the patient getting well apparently in spite of the lesion. One of the most remarkable instances of this kind that I have ever seen occurred recently in a young man, a private patient of mine, who, notwithstanding a most severe attack of caries of the superior cervical vertebræ, has obtained a very good use of the neck, although the upper portion is so completely ankylosed that, in attempting to look sideways, he is obliged to turn his whole body around. A great exuberance of callus has formed over the affected pieces, giving the neck a very full, heavy appearance.

When the cervical vertebræ are extensively affected, the disease not unfrequently proves fatal, death occurring in one of several ways. First, an abscess may form, and destroy life, either by bursting into the larynx, or into the spinal canal; in the one case instantly suffocating the patient, and in the other hardly less certainly killing him by inducing compression of the spinal cord. Secondly, dislocation of the odontoid process may occur from ulceration of the transverse ligament; and, lastly, life may be suddenly extinguished by injury inflicted upon the spinal cord, by the accidental displacement of some of the diseased vertebræ.

Mode of Repair.—The manner in which the gap is filled up, when a cure is effected in this disease, constitutes one of the most interesting features in its history. As soon as the morbid action is arrested, nature sets up a process of repair, consisting, in the first instance, in an effusion of plastic matter. This often begins at one part, while the disease is still going on in another; a circumstance which greatly conduces to recovery, as much time is thus saved. The restorative process advancing, the plasma is gradually organized, and thus becomes the nidus of the new bone by which the breach in the bodies of the vertebræ is finally closed up, the development of the osseous tissue taking place in strict conformity with the laws of ossification in the fetus. The new substance is extended, like a bridge, across the spinal canal, and does not, therefore, encroach at all upon its contents; it is more solid than the natural bone, and is usually several shades whiter. It connects together not only the contiguous bodies of the vertebræ, but also the remnants of the arches and spinous processes, soldering them into one solid, immovable mass, as in fig. 118. The heads of the adjoining ribs generally experience a similar fate. It will thus be seen that the cure of this disease is by ankylosis.

Treatment.—Caries of the vertebræ being merely, as already stated, a local manifestation of a general strumous vice, its treatment necessarily resolves itself into topical and constitutional, the latter holding the chief rank. I include, of course, among the constitutional means, rest in the recumbent posture, one of the most important elements of success in the management of every case of this kind, as an absolute, indispensable condition, not to be violated or departed from on any account whatever. If any one should be inclined to doubt the value of this precept, it will

Fig. 118.



Remarkable Example of Angular Curvature and Ankylosis, with spontaneous Cure.

only be necessary for him to look around and behold the many hump-backed persons that everywhere meet his eye, to be satisfied of his error. Every object of this kind is a standing, living monument of the miserable treatment that is so generally pursued. The very nature of the case suggests the propriety of absolute rest and recumbency. One need only observe the havoc committed by the disease to be convinced how utterly impossible it is for the weakened and crippled spine to support the superincumbent head and shoulders; it must inevitably yield under the heavy weight, and the distortion thence resulting must necessarily be in direct proportion to the amount of pressure thus maintained, and the extent of the gap left by the destruction of the bodies of the vertebræ. The reason why the curvature is posterior, is because the spinous, oblique, and transverse processes, preserving their integrity, tend, through the agency of the muscles that are attached to them, to drag the affected parts in that direction. Now, all this may be effectually obviated by the observance simply of the recumbent posture, maintained faithfully and steadily, not for a few weeks or months, but until nature has succeeded in bridging over the gap with new bone, capable of supporting the superincumbent weight. Until this be accomplished, the patient must on no account be permitted to rise off his couch for any purpose whatever. The completion of the cure is always announced by the solidity and firmness of the affected parts, by the indurated and enlarged condition of the structures immediately around the seat of curvature, and by the subsidence of the more important functional symptoms.

It is a mistake to suppose that a person laboring under caries of the spine will not brook confinement, or that confinement will tend to impair the general health; those who have the largest experience in this matter know better. A child may be taught obedience to anything, especially when it is designed to relieve pain and suffering; he may resist at first, but a few days are generally sufficient to break him in, and to make him docile and contented, if not perfectly happy. It is not necessary that he should lie all the time in one posture; the prone position is undoubtedly the best, as it relieves the parts of congestion and pressure, but he may lie on his back, side, or belly, as he may find it most agreeable, and generally he manages this matter of his own accord, without any prompting from any one. No pillow should be placed under the head, as it is important that the occiput should be on a line with the spine, in order that no pressure whatever may be made upon the affected parts. The bed may be a common trundle one, with a good hair, sponge, or cotton mattress.

The nature of the constitutional remedies must depend upon circumstances. The patient will, commonly, be immensely benefited by a course of chalybeate tonics, quinine, cod-liver oil, and a light but nutritious diet, with an occasional dose of blue mass. If fever be present, or if marked disorder of the bowels and secretions exist, an active purgative may sometimes be required; but, in general, it will be most judicious to avoid the employment of all kinds of depressants. The pain may be such as, occasionally, to demand an anodyne, especially if it is so great as to interfere with sleep. Night-sweats are best relieved by quinine and aromatic sulphuric acid, ablutions with tepid alum water, dry frictions, and exposure of the body to the fresh air. Milk punch, ale, porter, and wine may be used when there is unusual debility.

The principal local remedy is an issue made with the actual cautery, which is incomparably superior, so far as my experience enables me to judge, to every other mode of counter-irritation of which I have any knowledge. It should be placed either on one side of the affected part, or immediately below or above, as may be deemed most convenient, and should be at least as large, when the eschar has dropped off, as a half dollar. Such a sore will not only yield an abundant discharge of pus, easily maintained for several months, but afford an excellent surface for the endermic application of morphia, if this should be considered necessary, on account of the severity of the pain. The ordinary pea issue is of no use in such a disease, while that made with Vienna paste is altogether inferior to one made with the hot iron, which, besides destroying the integument, makes a much more powerful impression both upon the part and system. As to the seton, Mr. Pott long ago stigmatized it, in speaking of it in connection with this disease, as "painful and nasty;" an opinion in which, I am sure, every surgeon of experience must concur. If the discharge from the issue flag, it must be promoted by the application of stimulating unguents, a small blister retained for a few hours, or a little Vienna paste. A second application of the cautery is seldom necessary.

Although an issue is of great value in this affection, it must not be employed indis-

criminally. It is more particularly adapted to the earlier stages of the affection, and to children of good constitutional stamina. When the system is worn out by long suffering, it does harm instead of good.

When the parts have been sufficiently repaired to enable them to sustain the weight of the head, the patient may be permitted to rise, and to take exercise in the open air, provided with a suitable supporter. Such an instrument, to answer fully the object which it is intended to subserve, should combine lightness with strength, and should be constructed in such a manner as to come well up under the arms, at the same time that it makes gentle yet efficient pressure against the weakened spine, in the greater portion of its length. A hollow pad may be adapted to the angular projection behind. An idea of what such an apparatus should be may be formed by a reference to fig. 119.

Although I am not, as a general rule, an advocate for artificial support, as the patient lies in bed, in the ulcerative stage of the disease, yet such an expedient is sometimes indispensably necessary to counteract the tendency to displacement, particularly when the child is very restless, difficult to control, or constantly inclined to double itself up, as it were. When the disease involves the cervical vertebræ, such a precaution is especially proper, inasmuch as the affected pieces might, in an unguarded twist of the neck, suddenly cave in, and thus seriously compress, if not fatally crush, the spinal cord.

Fig. 119.



Apparatus for the relief of Posterior Curvature.

SECT. VII.—PSOAS ABSCESS.

In consequence of disease of the vertebræ, pus not unfrequently forms at the anterior and lateral aspect of the spine, which, as it accumulates, gradually descends towards the lower part of the trunk, where it ultimately points and is discharged, the event being preceded by the appearance of a fluctuating swelling. When the fluid passes down in front of the psoas muscle, the disease takes the name of psoas abscess, whereas, when it proceeds backwards towards the loins, it is called lumbar abscess; a distinction which, although topographically correct, must not be regarded as implying any difference in the nature of the two affections, inasmuch as observation has proved them to be perfectly identical in character.

An abscess of this kind is essentially a strumous disease, which can occur only in persons of a strumous predisposition. It is not surprising, therefore, that it should often be associated with tubercular disease in other parts of the body, especially of the lymphatic glands, lungs, and mucous follicles of the large bowel. The disease, rarely met with before the age of puberty, is most common between that period and thirty-five. I have rarely seen it in very young, and never in very old, subjects. Both sexes are liable to it, but males suffer from it much more frequently than females. It generally comes on without any assignable cause, although the patient is very apt to attribute it to the effects of cold, sprains, blows, or sudden twists of the body. Its march is always essentially chronic.

Dissection shows that this form of abscess almost invariably takes its rise in strumous disease of the bodies of the vertebræ, commencing either upon their outer surface or in their cancellated structure. Occasionally there is reason to believe that the starting point is the intervening fibro-cartilage, or the neighboring periosteum.

The abscess is generally developed in the areolar tissue in front of the psoas muscle; but instances occur, although rarely, in which it is situated at its lateral aspect, behind, or within its substance. In the latter event, it is usually of an elongated spindle shape. The complaint sometimes exists on each side of the pelvis, arising either simultaneously or successively. The contents of a psoas abscess are of a tubercular character, precisely like those of a chronic abscess in the soft parts or of a strumous joint. They are usually intermixed with flakes of lymph, and cases occur in which they contain small particles of bone, or of bone and fibro-cartilage. The fluid, the quantity of which varies from a few ounces to several quarts, is always inclosed by a distinct cyst, rough or villous internally, and firmly connected to the neighboring structures; it is of a dense, fibrous texture, and ranges in thickness

from the fourth of a line to the sixth of an inch. In cases of long standing, its length sometimes reaches an extent of fifteen to eighteen inches, forming either one continuous pouch, or exhibiting a more or less sinuous arrangement. The psoas and iliac muscles are always atrophied, inflamed, discolored, and partially transformed into fatty matter.

The *symptoms* of spinal abscess—for so this disease should be called, rather than psoas or lumbar abscess—are variable. The morbid action always begins in a slow, stealthy, and insidious manner, the patient being entirely unconscious for a long time that he is the subject of so serious an affection; he feels, perhaps, somewhat unwell, and finds that he is gradually growing weak and losing flesh and appetite; his face looks pallid, his sleep is irregular, and he occasionally has slight attacks of fever, followed by perspiration. At a still later period, exercise becomes exceedingly irksome, and he now begins to limp, especially after walking; he also finds it difficult to extend his trunk and thigh, so that, when he is up or going about, he is obliged to lean forwards a little towards the affected side, in order to relieve the parts of tension. A good deal of soreness is usually complained of in the back and iliac regions, extending along the front of the thigh; but anything like severe pain is seldom felt. After some time, varying from three to six months, a tumor becomes perceptible, soft, compressible, and fluctuating distinctly under the finger. When seated in the groin, or in the upper part of the thigh, it generally receives a marked impulse on coughing, and recedes more or less on recumbency, especially when conjoined with considerable elevation of the pelvis. In the lumbar and gluteal regions, on the contrary, coughing and position usually make no impression upon it.

The symptoms are at first not well marked. There is no uniformity in regard to the precise spot where the abscess points, although this is generally just above Poupart's ligament, external to the iliac vessels. Sometimes the matter gravitates down in front of the thigh, beneath Poupart's ligament; and I have met with cases where it showed itself on the outside of the limb, upon the nates as low down as the tuberosity of the ischium, in the iliac region above the anterior superior spinous process of the ilium, and in the interior of the pelvis, its contents being finally evacuated into the bowel or bladder. Pointing in the lumbar region is by no means uncommon. In a few rare instances the matter has been known to issue at the perineum or at the thyroid foramen, forming a tumor at the upper and inner part of the thigh. The period between the commencement of the disease and the occurrence of ulceration varies, on an average, from four to six months.

The march of psoas abscess is usually steadily onward; so long as the sac retains its integrity the system is often comparatively little affected, but as soon as it is opened, whether spontaneously or artificially, and the air is permitted to mingle with its contents, the constitution manifests at once the most lively sympathy, as is evinced by the rapid supervention of rigors and hectic fever, with all its train of evils.

The *diagnosis* of psoas abscess is generally not difficult. Indeed, the symptoms just described are usually quite sufficient for the purpose. The chief elements of distinction are, the history of the case, the slow progress of the disease, the gradual but steady failure of the general health, the dull, heavy, aching pain in the lumbar, iliac, and inguinal regions, the difficulty in walking, the bent position of the trunk and thigh on the affected side, and the appearance in the course of the psoas muscle, at a variable period after the commencement of the complaint, of a soft, fluctuating swelling, free from discoloration, without pain or tenderness on pressure, receding during recumbency, and receiving a distinct impulse during coughing.

When the abscess points in the groin, a superficial observer might mistake it for an inguinal hernia; but the history of the case, the distinctness of the fluctuation, and the situation of the swelling, which is usually much nearer to the spine of the ilium than in rupture, will always afford just grounds for a correct diagnosis. When the tumor appears at the upper and inner part of the thigh, the only disease with which it is liable to be confounded, in its earlier stages, is femoral hernia; a very rare affection, most common in females at an age when psoas abscess does not occur. The symptoms, indeed, of the two complaints are so diametrically opposite as to render error of diagnosis a matter almost of impossibility.

The distinction between psoas abscess and iliac abscess is sometimes attended with difficulty, especially in their earlier stages. The former, as already seen, is always connected with disease of the spine, while the latter is generally due to the

effects of cold, rheumatism, external injury, or the lodgement of irritating matter in the cæcum or vermiform appendix. It often occurs in females of a weak, delicate constitution, as a consequence of parturition. Psoas abscess is most common in young subjects; iliac, in middle-aged and elderly. Pain in the back and tenderness of the lumbar vertebræ are common to both affections. In iliac abscess there is usually more suffering, both local and general, than in psoas, and the matter, as a rule, points above Poupart's ligament, nearer to the anterior superior spinous process of the ilium. In psoas abscess the trunk is more inclined forwards, and there is a greater degree of flexion of the thigh upon the pelvis, while much more difficulty and distress are experienced when an attempt is made to extend the limb, owing to the tension and rigidity of the psoas muscle.

The *prognosis* of this disease is generally unfavorable, most patients perishing from its effects in from twelve to eighteen months. Very few, if any, ever make a good, permanent recovery. In the great majority of cases death occurs from hectic irritation, profuse sweats, and colliquative diarrhœa, either as the direct result of the abscess, or of the abscess and of lesion of other organs, especially of the lungs and bowels. A case of large lumbar abscess, in which death occurred from profuse hemorrhage from ulceration, as was supposed, of one of the lateral sacral arteries, has been reported by Dr. John Ashhurst, of this city.

The *treatment* of spinal abscess is altogether unsatisfactory. Generally, several months elapse before the true nature of the disease is ascertained, and then its ravages will usually be found to be of such a character as to render all efforts at a cure utterly hopeless. If a free, dependent outlet could be formed for the matter early in the disease, the probability is that the patient might occasionally get well; but when it is considered how much the osseous and other structures suffer before the fluid reaches the surface, it is not surprising that these cases should so uniformly prove fatal. Moreover, it is not to be forgotten that the abscess is merely a symptom of a general tubercular dyscrasia, which is, in itself, an unfavorable omen, as it is always likely to be followed by serious disease in other, and, perhaps, still more important organs. If the affection be left to itself, it will be sure to destroy life, and the event will hardly be any the less certain if it be surgically interfered with. Subcutaneous evacuation of the matter, as proposed by Abernethy, is not of the slightest use as a curative agent; in the many cases in which I have tried it, no benefit whatever resulted, except that it occasionally afforded temporary relief from pain. The operation is always, in a very short time, followed by hectic fever, and by more or less rapid failure of the health and strength, no matter how carefully it may have been performed. Very frequently not even palliation is derived from it. To moderate the reaction consequent upon the ingress of the air, opium should be given, especially for the first few days, in large and sustained doses. Sorbefacient applications, in the form of lotions, unguents, or plasters, are of no particular use. When the sac has been opened spontaneously, advantage may sometimes accrue from the injection, twice a day, of tepid water, followed by some slightly astringent and anodyne fluid, or a very weak solution of iodine; but too much caution cannot be observed in the employment of this and similar measures, lest violent local and constitutional irritation be excited, thereby hurrying off the patient. Alterants may do good by improving the general health, but not as curative measures. In the latter stages of the disease, tonics and a nutritious diet will be necessary, with aromatic sulphuric acid to allay perspiration, and anodynes to procure sleep and arrest diarrhœa.

SECT. VIII.—HYDRORACHITIS.

Hydrorachitis is a congenital defect, consisting in a cleft of the vertebral column, with a protrusion of the lining membranes of the spinal cord. The lesion, caused by an arrest of ossification, and consequent deficiency of the vertebral rings, is generally situated in the lumbar region, but occasionally it affects the dorsal, cervical, or even the sacral. It is frequently associated with hydrocephalus, and is analogous to those malformations which originate from a want of union of the two halves of the fetus during uterogestation, such as harelip, cleft palate, and umbilical hernia.

The adjoining drawing, fig. 120, from a clinical case, a child six weeks old, shows a rare form of this disease. The tumor, which was seven inches and a half in circumference, was quite soft, fluctuating, and tender on pressure, although free from inflammation. The general health was excellent.

The malformations of the spinal column accompanying this affection may be arranged under the following heads: 1, division of the entire vertebra, even of its body; 2, partial or complete absence of the lateral arches; 3, perfect development of the lateral arches with want of union at the median line.

Fig. 120.



Hydrorachitis of the Neck.

Fig. 121.



Bifid Spine, the Sac being laid open.

The protrusion of the spinal envelops generally takes place during the latter months of foetal life; occasionally, however, it is not observed until some weeks or months after birth. When the tumor first shows itself, it may not be larger than a pea; but, as the disorder progresses, it gradually increases in size, varying in proportion to the deficiency of the vertebræ. Although the swelling usually does not exceed the size of an orange, it occasionally reaches that of the fist, and even of the patient's head. The skin is commonly very smooth, delicate, and thin; sometimes, however, it retains its normal thickness, or it becomes red, rugose, and horny; in a few rare cases, it is entirely wanting. The tumor is either soft, flabby, and fluctuating, or it is full, hard, and shining; when pressed upon, it gradually diminishes in volume, or completely recedes; but no sooner is the force removed than the fluid reaccumulates, and the part regains its previous bulk. In its form, the swelling is globular, ovoidal, or pear-like, with a short, narrow neck, by which it reposes upon the cleft bone. Fig. 121, from a preparation in my possession, exhibits a tumor of this kind in the lumbar region; it was about the size of a common orange, and was taken from a child five months old. Its cavity, which is here laid open, had been exposed by ulceration.

The fluid in hydrorachitis is generally of a thin, limpid character, slightly saline in its taste, and almost uncoagulable. In some instances, it is of the color and consistence of synovia, or it contains flakes of lymph and particles of pus. These appearances, however, are seldom present until after the swelling has burst and discharged its original contents. The tumor usually consists of a single cyst; but there may be several, as in the multilocular variety of ovarian dropsy.

The contents of the vertebral canal in the immediate neighborhood of the lesion are variously affected. The portion of the spinal cord surrounded by the tumor is often very much softened; and, on the other hand, it may be abnormally hard; sometimes it is not so large as natural; and cases occur in which it deviates remarkably from its accustomed route, being forced through the opening in the vertebræ, and partially contained in the swelling. The nerves are always more or less displaced; very often, indeed, they are dragged out of the canal, and spread over the inner surface of the cyst in a beautiful plexiform manner, not unlike that of the fleshy columns of the heart, as exhibited in fig. 122, from a preparation in my collection.

Hydrorachitis is one of the most fatal of diseases. Few children survive their birth longer than five or six months, while many perish in a much shorter time, death

being caused either by convulsions, or by ulceration of the sac, and the sudden escape of its contents. It is true, life has sometimes been sustained until the age of puberty, and, in one case, until the fifty-fifth year; but such instances, although encouraging in a practical point of view, are altogether exceptional, and cannot, therefore, be used for the establishment of any general law. In a case under my charge at the College Clinic, in 1866, the patient, a girl, had attained her thirteenth year, but she was exceedingly anemic, and horribly deformed by lateral curvature of the spine. The tumor, situated in the lumbar region, was of the size of a large fist, without any pain, discoloration, or apparent tendency to ulceration. If the sac is ruptured during parturition, the infant is nearly always still-born, and if it is opened after birth, either accidentally or designedly, death usually follows in a few hours, the immediate cause of dissolution being convulsions from the pressure being taken off the brain in consequence of the loss of the cephalo-spinal liquid. The case is always likely to have a speedily fatal termination when it is associated with hydrocephalus, paralysis of the inferior extremities, or involuntary discharge of the urine and feces. Moreover, it may generally be regarded as being of a more hopeless character when it affects the cervical region than when it is seated in the dorsal, lumbar, or sacral.

A spontaneous cure is a rare event in this affection. It is generally due to a rupture of the sac, followed by the escape of its contents, and the gradual shrinking of its walls. In a case related by Hana, rupture of the sac occurred after measles, and the child recovered.

Treatment.—The treatment of bifid spine is anything but satisfactory. When the tumor is small, or of moderate size, a cure may occasionally be effected by keeping up constant pressure with collodion and a common roller, or a cup-shaped truss, lined with a thin air-cushion, so as to diffuse the pressure equally over the entire swelling. The compression should be aided by the occasional evacuation of the contents of the sac by subcutaneous puncture with a very fine trocar or bistoury, the opening being well closed immediately after, to prevent the introduction of air. Only a portion, however, of the fluid should be drawn off at a time; if the whole be removed at once, convulsions will be inevitable, and from such an attack the child may perish in a few hours, the brain being unable to bear the sudden loss of pressure caused by the escape of the cephalo-spinal liquid. Sir Astley Cooper, early in life, treated successfully a case of this kind by simple compression alone; and, in another instance, soon afterwards, he was equally fortunate by combining this method with repeated punctures, as had been previously proposed by Mr. Abernethy. Subsequently, he employed the same measures in two other children, one of which perished, very unexpectedly, at the end of forty days, everything having before been in a promising condition, while the other recovered, at the expiration of a year and a half, after the tumor had been punctured thirty times, and the case had been given over as lost. Favorable results have also followed this plan of treatment in the hands of other practitioners, both in this country and in Europe, and is, I am satisfied, the only safe one of which we have at present any knowledge. The smaller, of course, the tumor is, the more likely it will be to succeed; if it is of inordinate size, or even if it is comparatively diminutive with a broad base, and a large cleft in the vertebrae, no treatment of any kind can be of any but the most transient benefit, and then only in the way of support with a view to the prevention of ulceration and the accidental rupture of the sac.

Foresters, Benjamin Bell, and other surgeons have suggested tying the base of the sac with a ligature, with a view of removing the tumor, and preventing further propulsion of the spinal membranes; but the results that have been published in favor of the operation are hardly such as to warrant a repetition of it. I have myself the particulars of several cases of this kind that have come either under my own immediate observation, or that have been communicated to me by different prac-

Fig. 122.



Bifid Spine, showing the Disposition of the Nerves.

tioners, and in every one the effects have been most lamentable, the patient dying either immediately after the operation from convulsions, or a short time afterwards from an extension of the inflammation to the spinal cord and its envelops. The same may be said of the operation of excision after ligation of the pedicle, and the application of the actual or potential cautery for the purpose of exciting adhesion between the opposing surfaces of the sac. All such procedures cannot be too pointedly condemned, as being both unscientific, and certain to prove fatal. The reason for the mortality from these operations is evident when we consider that in at least ninety per cent. of the cases the sac contains either a segment of the spinal cord or nervous filaments spread out upon its interior. The only case in which ligation can ever be proper is where the sac has an uncommonly narrow pedicle, with an exceedingly small aperture of communication, but even then the safer practice unquestionably would be systematic compression in union with occasional puncture. Mr. Edward Sidebottom, of England, recently reported a case successfully treated by ligature, followed by sloughing of the tumor at the end of the third week.

Dubois, with the hope of gradually diminishing the size of the tumor, and of ultimately agglutinating the serous surfaces at its base, proposed the application of pressure, at this particular point, by means of two narrow steel plates, regulated by two screws, and prevented from slipping by passing two stout needles immediately in front of them, across the swelling. In this manner he succeeded, it is alleged, in curing his patient.

Finally, it has been proposed to cure hydrorachitis by injections of iodine; an operation first performed by Dr. Brainard, in 1848, and subsequently repeated by him, up to 1859, in five other cases. In addition to these he reported five cases that had occurred in the hands of other surgeons, and it would seem that neither in these nor in his own were there any dangerous effects produced. Practitioners generally, however, have certainly not been equally fortunate. In two cases of my own, and in several others reported in the medical periodicals, the operation was followed by death, either from the rupture of the sac, or the severity of the resulting inflammation. Whether the procedure is as free from danger, or as successful, as the facts presented by Dr. Brainard would seem to warrant, is a question which time alone can determine. The most unfavorable cases, of course, are those in which the disease is complicated with hydrocephalus.

The rules laid down by Brainard for performing the operation are: 1st, to make the puncture subcutaneously in the sound skin, by the side of the tumor; 2dly, to draw off no more serum than the quantity of fluid about to be injected; 3dly, to evacuate the contents of the sac, if symptoms of irritation supervene, and to replace them immediately with distilled water. The patient should lie on his side or face after the operation, and, if there be much heat, warm, evaporating lotions should be applied to the part and head. As soon as the tumor becomes flaccid it should be covered with collodion, or supported by pressure, continued for some weeks after the cure has been perfected; and, lastly, the injection should be repeated as often as may be necessary, care being taken that the previous irritation has completely subsided.

The operation is performed with a very delicate trocar, the puncture being accurately closed with adhesive strips. The active ingredients of the solution are iodine and iodide of potassium, in the proportion of one-fourth of a grain of the former and thrice that quantity of the latter to the ounce of distilled water. When the sac is very thick and pedunculated, the strength of the solution should be much greater than ordinary, and the tumor, after being entirely emptied, should be thoroughly injected, washed out, and immediately refilled either with its original contents or with distilled water. Pressure is applied during the operation in such a manner as to prevent any of the solution from entering the spinal canal.

SECT. IX.—HYSTERICO-NEURALGIC AFFECTIONS.

The spine is liable to a peculiar nervous affection to which the term *hystericoneuralgic* may very properly be applied, as denotive of its pathological character. Although not very common, it is sufficiently frequent to render it an object of great practical importance, the more especially as it is extremely apt to be confounded with *psoas abscess* and *tuberculosis of the spine*. Sir B. C. Brodie, in speaking of

it, remarks that he had "known, not a few, but very numerous, instances of young ladies being condemned to the horizontal posture, and even to the torture of caustic issues and setons, for several successive years, in whom air and exercise, and cheerful occupations, would probably have produced a cure in the course of a few months."

The disease is met with chiefly in young females of a nervous, hysterical temperament, and generally coexists with disorder of the menstrual function and neuralgia in different parts of the body. It essentially consists in a hyperæsthetic condition of the spine, usually confined to some particular spot, from which, however, it is liable to shift to other parts. The sensibility frequently amounts to excessive pain, so that the slightest pressure, or motion, is productive of exquisite suffering. Sometimes the whole spine is tender. I have seen cases where the pain was limited, in great degree, to a single vertebra. The portions of the spine most commonly affected are the lumbar and dorsal. Occasionally the distress is located mainly in the coccyx, sacrum, or sacro-iliac symphysis.

The pain, as may always be readily determined by a careful examination, is often confined entirely to the skin, especially in the earlier stages of the attack, and is frequently so severe as to render the slightest touch a source of extreme suffering. Even the pressure of the clothes is sometimes intolerable. It may be of a dull, aching character, or sharp and shooting; and it is not uncommon for it to radiate about in different directions, extending, perhaps, into the chest, abdomen or pelvis. The general health always suffers. The appetite is irregular and capricious, the bowels constipated, the tongue more or less coated, the sleep disturbed and unrefreshing, the extremities habitually cold, and the whole surface remarkably susceptible to atmospheric impressions. Menstruation is scanty and painful; the urine high-colored and coated with lithic acid; the mind suspicious and excitable.

In the worst forms of the disease, the patient loses all control over herself. The legs are weak, and almost unable to support the weight of the body; the muscles are affected with involuntary spasms; prickling sensations are experienced in the limbs; the breathing is embarrassed by a sense of constriction, in the chest; there is occasional retention of urine; and at length the capacity for bodily exertion and social enjoyment completely vanishes.

Great care is necessary not to confound this disease with tuberculosis or spinal abscess. The danger of mistake exists chiefly in the earlier stages of the attack. After it has become chronic, the symptoms are generally too well marked to admit of error. The best way to avoid a wrong diagnosis is to subject the patient to frequent examinations, and to proceed upon the principle of exclusion.

The treatment must be by mild, not harsh, measures. Issues, setons, blisters, and pustulation with tartar emetic seldom fail to aggravate the mischief. The applications should be soothing, and consist mainly of anodyne plasters and embrocations. Even leeches are rarely of any use. The system should be built up with tonics, gentle exercise in the open air, travelling, the shower-bath, dry frictions, and a nutritious diet with alcoholic stimulants. A residence at the seashore is often highly advantageous; and nothing contributes more to the comfort of the patient than cheerful occupation. When the symptoms are of a decidedly hysterical character, benefit will accrue from valerian, assafœtida, and, above all, from large doses of bromide of potassium. In all cases the bowels and secretions must receive due attention.

SECT. X.—CARCINOMA OF THE VERTEBRÆ.

Carcinoma of the spinal column is singularly uncommon. The form in which it generally presents itself is the encephaloid, or scirrho-encephaloid; that is, a combination of the hard and soft varieties. Of scirrhous, properly so called, the records of surgery afford very few examples. The carcinomatous mass is, now and then, interspersed with melanotic matter, especially in the earlier stages of the disease, but the occurrence is exceedingly infrequent. Colloid of the vertebral column is almost unknown.

The carcinomatous matter may occur in two varieties of form, either as an infiltration, or as a distinct tumor, varying in size from that of a filbert to that of a pullet's egg, of a white, grayish, or slightly yellowish hue, interspersed with small bloodvessels, and of a semiconcrete, lardaceous consistence. In the more confirmed stages of its progress, when it is broken down and disintegrated, it is almost as soft as cream.

The most common site of the disease is the dorsal portion of the spine, next the cervical, and, lastly, the lumbar. The sacrum and coccyx seldom suffer. The special seat of the deposit is the spongy structure of the vertebræ, but in its progress it is liable to encroach upon the arches and even the processes, as well as upon the soft structures around. When the osseous tissue is destroyed, the matter extends towards the spinal canal, and, in rare cases, affects the meninges and even the spinal cord. The number of vertebræ involved varies generally from three to five or six. In a case of cancerous diathesis observed by Sansom nearly every piece of the column was implicated. The affection is for the most part of a secondary character.

The most important symptoms are, pain, at first fugacious, indefinable, sometimes seemingly rheumatic, but gradually increasing in violence, and at length becoming distinctly localized; exquisite tenderness on pressure; and inability to lie for any length of time in one particular posture. Posterior, or posterior and lateral, curvature may show itself during the progress of the disease, from interstitial absorption of the bodies of the vertebræ, on the same principle as in caries; and, when the soft parts around are involved, a tumor may form, as in some cases recorded by Hawkins, Taylor, and other observers. When the spinal cord is implicated, there will be numbness and formication, with partial paralysis, of the extremities. Special functions may be disturbed, according as the cervical, dorsal or lumbar vertebræ are the parts affected. None of these phenomena are diagnostic.

The treatment is of course merely palliative. All that can be done is to alleviate pain, and to smooth the patient's passage to the grave. Everything in the form of counter-irritation is not only positively useless, but likely to increase the suffering.

SECT. XI.—TUMORS OF THE BACK.

The morbid growths that are liable to occur in this region present nothing peculiar; they are strictly similar to those in other parts of the body, and, consequently, require the same kind of treatment. Of the benign formations the most common are the fatty and the fibrous, both of which occasionally attain an extraordinary bulk, especially when they are situated immediately beneath the integument. When this is the case, they are frequently also very pendulous, or of a peculiar gourd-like shape, with a comparatively narrow attachment.

The *fatty tumor* lies generally immediately under the skin; it is of slow growth, of a doughy, semielastic consistence, free from pain, and unattended with any enlargement of the subcutaneous veins, excepting in cases of great bulk, when these vessels may exhibit almost a varicose condition. Dorsey removed from the back of a negress a fatty tumor that weighed twenty-five pounds. It had existed for eighteen years, and, although it was covered merely by the skin, it had formed very firm attachments to the spinous processes of the vertebræ, as well as to the muscles and aponeuroses of the back. As a preliminary step, the patient was placed for fifteen minutes upon her abdomen, and the tumor elevated and compressed by assistants, in order to empty it of blood, very little of which was lost during the operation. Rapid recovery followed.

When the fatty tumor is developed upon the shoulder, it is liable to contract very firm adhesions, so as to require a tedious dissection for its removal. In a case under my care not long ago, the growth, which was hardly the volume of a large fist, was bound down very closely by the long-continued pressure that had been exerted upon it by carrying a pack.

The *fibrous tumor* of the back is generally deep-seated, lying beneath the muscles and aponeuroses, by which it is firmly bound down to the ribs. Its most important diagnostic features are, its tardy growth, its dense, firm consistence, its immobility, and its confined situation. The general health is commonly unimpaired, but the patient often experiences a good deal of pain, usually of a dull, aching character. The tumor manifests no disposition to ulcerate. It is most common in elderly subjects.

The back, shoulders, and trunk are often the seat of *pendulous tumors*, growths hanging off, as the name implies, from the surface, usually by a narrow pedicle, mainly composed of the common integument, or of skin and connective tissue. Fatty, fibrous, and sarcomatous tumors are most liable to present this arrangement, but others, as the cutaneous, vascular, and even the encephaloid, occasionally exhibit it. The annexed fig. 123 affords an excellent illustration of a pendulous fatty

growth, upon the back of a man upwards of forty years of age, a patient at the College Clinic. The mass had made its appearance a long time previously, and weighed at the time of its removal upwards of ten pounds. The operation was almost bloodless.

Apart from their pendulous character, these tumors present nothing peculiar, either as it respects their origin, structure, or mode of growth. When benign, as they usually are, they incommode chiefly by their weight, bulk, and situation. The general covering is usually sound, only, perhaps, a shade or two darker than that of the adjacent surface. The pedicle, however, is liable, from the constant traction exerted upon it, to become inflamed, discolored, œdematous, abraded, or even ulcerated. Gangrene might occur in such a condition from compression of the pedicle, leading to gradual obstruction of the circulation and the arrest of nervous fluid.

The *sebaceous tumor* rarely occurs upon the back. When it is developed here, its superficial situation, tardy growth, small size, and semielastic feel will always readily distinguish it from other formations.

Large *nævous growths* are sometimes met with here; generally of a venous structure, but occasionally of a veritable anastomotic nature, expanding freely under mental emotion, and pulsating synchronously with the heart. The venous form of the disease is sometimes associated with a varicose condition of the subcutaneous veins, and in this event an immense tumor may be formed, of a soft, spongy consistence, with a sensation, when it is firmly grasped, as if it were filled with bundles of earthworms. Many of the larger veins contain phlebolites.

Of the malignant tumors that are liable to appear in this region, by far the most common is the *encephaloid*. Sarcoma, scirrhus, epithelioma, melanosis, and colloid are exceedingly infrequent.

Of *sarcoma* of the back, I have only met with two examples; in one upon which I operated at the College Clinic, in a woman, aged sixty-four years, the tumor had many of the external features of a fibrous growth, but presented, when examined microscopically by Dr. Fricke, all the characteristics of a round-celled sarcoma. It had commenced nearly six years previously, was situated between the scapula and the spine, in close contact with the ribs, and was of an elongated, ovoidal form, its long diameter being upwards of six inches. The tumor had no capsule, but it was uncommonly vascular. The second case occurred in a man, thirty-eight years of age, upon whom I operated in October, 1871. The tumor, which was first noticed only six months previously in the subcutaneous connective tissue between the scapula and the spine, was firmly adherent to the skin, painless, soft at some points and comparatively hard at others, and about nine inches long by six inches broad. After removal it presented the characteristic gross and minute appearances of myxomatous sarcoma, and, although not a single vessel required deligation at the time of the operation, the man lost a large amount of blood thirty-six hours subsequently without any discoverable source of the hemorrhage.

The most formidable case of *epithelioma* I have ever seen occurred upon the back of an elderly man, directly over the middle line, between the shoulder-blades. It commenced without any assignable cause, spread with remarkable rapidity, and, when I first saw it, along with Dr. McWhinney, about six months after its origin, it was nearly of the diameter of an ordinary saucer. The ulcer had a deep, excavated appearance, with hard, puckered edges, and was the seat of a copious discharge of thin, sanious, and offensive matter. The most striking feature of the case was the existence of an immense number of secondary tubercles in the skin of the trunk and extremities, varying in size from a pea up to that of a half dollar.

The *encephaloid tumor* of the back is always, according to my observation, deep-

Fig. 133.



Pendulous Fatty Tumor.

seated, lying beneath the muscles, in close contact with the ribs, or ribs and spine. It is most common in elderly subjects; and is generally readily distinguishable by its rapid growth, its great size, its lobulated surface, and its soft, semielastic consistence. In its earlier stages, it is entirely free from pain, but, as it increases in bulk, its pressure upon the surrounding parts often causes great suffering. Left undisturbed, it manifests little, if any, disposition to ulcerate; and the patient may live several years before he is finally worn out by hectic irritation.

Melanosis, in this situation, is nearly always a secondary affection. Its black or bluish color, its situation in the skin and subcutaneous-cellular tissue, its nodular form, its small size, and its firm, dense consistence are features by which it may always be easily distinguished from other formations, whether malignant or benign.

The *treatment* of these various morbid growths requires no special notice. There is one point, however, which is deserving of particular consideration in connection with their extirpation when they are deep-seated, in close contact with the spine, or spine and ribs. When this is the case, an elaborate dissection is generally required for their liberation, and there is always great risk of copious hemorrhage, not so much from the arteries in this situation as from the veins, which form large plexuses at the junction of the ribs and the transverse processes of the vertebræ. When these vessels, which are destitute of valves, and which are known as the vertebro-costal veins, are divided, they pour out blood in great profusion, and in a manner which renders it frequently impossible to arrest it without the ligature.

In all deep-seated tumors of the back, the knife should be carried in a direction parallel to the spine, first through the integument, and next through the muscles, down to the morbid mass, which should then, if possible, be liberated by enucleation. Care should be taken not to cut into the morbid structure, especially if it is of an encephaloid nature, otherwise there will inevitably be profuse hemorrhage. Any large veins that may be divided should promptly be tied. The wound, after the operation is completed, should be well supported with a compress and bandage.

In the removal of pendulous tumors care must be taken not to cut off the skin too closely to the surface, otherwise, when the wound comes to be united, approximation may be impracticable from deficiency of integument. A pedicle, for instance, which is four inches long will, when the weight is taken off by lifting up the morbid mass, often shrink away to one-third of that length.

CHAPTER IV.

INJURIES AND DISEASES OF THE FACE.

THE face, considered as an independent region, is composed of thirteen bones, for the most part very thin and delicate or thick and porous, intimately connected together, and remarkably vascular. Its numerous muscles are chiefly concerned with the organs of mastication, taste, and sight. Its arteries are derived from the external carotid; its veins empty into the jugular; and its nerves proceed directly from the brain. The soft structures of the face are endowed with great sensibility, and their supply of blood is naturally very great; circumstances which exercise an important influence upon the injuries and diseases of this region of the body.

The principal affections to be considered under this division are the various kinds of wounds, especially the incised, contused, and gunshot, neuralgia, paralysis of the portio dura, and different forms of tumors.

Wounds and Contusions.—Incised wounds of the face present nothing peculiar, except that they are frequently attended with copious hemorrhage, especially when they penetrate to a considerable depth or involve the bones, which, as already stated, are remarkably vascular. In their treatment, the usual rules of practice are to be observed, but additional care is requisite in approximating and maintaining their edges, otherwise, when the cure is completed, the patient's countenance may be disfigured by an unseemly scar. The best retentive means are small, delicate pins, or the finest cambric needles, inserted in the same manner as in the operation for hare-

lip, the threads being so arranged as to obviate the necessity of adhesive strips, which, in no event, must alone be trusted, as they are extremely liable to be displaced by the action of the muscles of the face. I have myself long been in the habit of employing very slender gold pins in wounds of this region, and there is no mode of dressing that is so likely to be followed by a satisfactory cure. With a sharp point and a head of sealing-wax, they are easily introduced, and may be retained for almost any length of time without the risk of provoking irritation.

When incised wounds of the face are complicated with extensive separation of the soft parts, or of the soft parts and of the bones, it may be necessary, in addition to sutures, to use a compress, confined by adhesive strips or a suitable bandage, the object being to afford gentle and equable support to the flaps.

Contused and lacerated wounds of the face are liable to be followed by very unpleasant effects, both temporary and permanent. Among the former are blood-stains, ecchymoses, extensive tumefaction, severe pain, and erysipelas; among the latter, disfiguring scars and paralysis of some of the muscles from injury to their nerves.

A curious wound of the face, partly contused and partly incised, is occasionally inflicted by a blunt weapon operating upon the sharp border of the superior maxillary and malar bones. The parts present very much the appearance as if they had been divided by the sharp edge of a knife, at the same time that they are more or less bruised, and perhaps even discolored. A similar effect is occasionally produced by the edges of the teeth driven forcibly by a blunt body against the lips and cheeks.

In the treatment of these lesions, the most important indication, after the removal of foreign matter, is the gentle approximation of the parts with the pin or wire suture, followed by cold water-dressing, aided, if there is much contusion, by the addition of a little alcohol. The edges of the wound must be placed in the most accurate apposition, and the greatest care taken to keep down inflammatory excitement.

Contusions, properly so called, of the face are always attended with more or less bleeding into the connective cellular tissue, elevating and discoloring the skin, the hues varying from slight purple to deep scarlet, which, during the progress of the case, in consequence of the changes effected in the extravasated fluid, gradually diminishes in intensity, becoming at first brownish, then greenish, and finally yellowish. The most common sites of these effusions are the eyelids and cheeks, on account of the great abundance and laxity there of the areolar substance readily admitting of infiltration. One of the best examples of such an accident is the "black eye" of the pugilist, caused by the rupture of the vessels of the lids and the extravasation of their contents into the connective structures. Considerable swellings of this kind are occasionally met with in the lips and chin, and even upon the nose, especially its upper part. In fractures of the base of the skull, large quantities of blood are often poured out into the cellular tissue of the orbit, surrounding and compressing the globe of the eye.

The most suitable remedies for the relief of these accidents are cold water and sorbefacient lotions. When there is much local disturbance, the best application, at least for the first few days, is a moderately strong solution of acetate of lead, Goulard's extract, or hydrochlorate of ammonia, with a small quantity of laudanum. For the milder forms, the tincture of arnica, more or less diluted, is often very beneficial, the pain, swelling, and ecchymosis rapidly disappearing under its influence. Weak spirituous lotions, camphor water and laudanum, or a mixture of vinegar and water, may also be employed with advantage. When the extravasated blood refuses to yield to these and other measures, as occasionally happens when the parts are very much bruised, or when the fluid exists in large quantity or is devitalized, the best plan is to let it out by means of a small puncture, otherwise it may cause suppuration and other unpleasant effects.

Gunshot Wounds.—Gunshot injuries of the face are most liable to occur, when men are fired at behind entrenchments. During our late war, 4167 cases of these lesions, or 4.7 per cent. of the entire wounded, came under treatment. Of this number 1579 were examples of fractures of the facial bones, and 2588 of flesh wounds. Of the former 891 recovered, 107 died, and the terminations were not ascertained in 581 cases. The principal source of mortality was secondary hemorrhage, which was a frequent complication of these injuries. In the Crimean war, altogether 533 cases of these lesions came under treatment among the English soldiers, or 7.4 per cent.

of the entire wounded. Of this number 382 were cases of simple flesh contusions and solutions of continuity, 272 being slight, and 108 severe. In 107 cases the wounds penetrated or perforated the osseous structures, and in 44 they were complicated with injuries of the eyes; in 42 of one, and in 2 of both. Of the entire number only 14 died, or 2.6 per cent. of those treated. Of 40 cases which occurred among the officers, including 15 of more or less severity, not one proved fatal.

The mortality in gunshot wounds of the face would thus appear to be remarkably slight, a circumstance which is the more surprising when it is recollected that these injuries are often attended with severe laceration of the soft parts and extensive fracture and comminution of the bones. The immunity, however, is readily accounted for by the fact that the face contains no vital organ, by the large quantity of blood sent to this region, and by the free anastomosis of its vessels. For these reasons the fleshy and osseous structures readily unite in cases, generally, even of an apparently desperate character. For the same reason mortification and necrosis here, as a result of contusion and fracture, are extremely rare.

Wounds of the face from shell, grape, and cannon shot are, other things being equal, more dangerous than those inflicted by the Minié or common rifle ball. The risk from hemorrhage, erysipelas, and pyemia, is much increased, and the deformity is often frightful and irremediable, the lesion, perhaps, involving the lips, nose, cheeks, jaws, tongue, and one or both eyes.

In the treatment of gunshot wounds of this region, the rule is to save all and sacrifice nothing, as it is impossible, in any case, to determine beforehand whether the parts, even if desperately injured, will not readily heal when properly dealt with. Perfectly loose or detached pieces of bone should, of course, be removed, and any rough or sharp angles that may exist should be pared away with the pliers, so as to place them in a better condition for ultimate, if not speedy, reunion. The edges of the soft structures may sometimes also be advantageously trimmed or smoothed off, although care should be taken not to remove any more than is absolutely necessary to insure their more accurate apposition. Maintenance is effected by the wire suture, aided by adhesive strips; the roller may usually be dispensed with. If the injury is very extensive, tepid water-dressing, with the addition of a little alcohol or tincture of arnica, will answer better than cold, at least for the first few days; but in general the latter will be preferable.

One of the great sources of annoyance and danger in gunshot injuries of the face is hemorrhage, which is often exceedingly profuse and difficult to arrest, from the great depth of the vessels, or the manner in which the blood wells up at the bottom of the wound. The only way to put an effectual stop to it is to secure every bleeding artery, however minute. When the trunk of the internal maxillary is divided, each extremity must be included in a separate ligature, precisely as in hemorrhage of the main artery of a limb. When the blood oozes out at numerous points, the flow may usually be easily arrested with the tampon, or the tampon and styptics, of which Monsel's salt and ice are among the very best. In desperate cases, it has been proposed to tie the common carotid artery, but such an expedient can seldom, if ever, be successful, owing to the free anastomosis of the branches of the two opposite vessels.

Secondary hemorrhage is of frequent occurrence in these lesions, sometimes commencing within a short period after the accident; and, although it may cease spontaneously, it is occasionally controlled with much difficulty.

When the injury of the fleshy structures is accompanied with extensive fracture of the bones, the fragments should be carefully moulded into shape, and retained by light dressings. Every thing like severe pressure must be avoided, as the parts are particularly intolerant of such interference.

When a large portion of the lower jaw is shot away, the tongue, having lost its muscular connections, is liable to fall back upon the glottis, threatening suffocation. To counteract this tendency, all that is generally required is to place the head in the prone position. If, notwithstanding this precaution, alarming symptoms arise, the point of the tongue should be transfixed with a silver wire, so that the organ may at any moment be drawn forward by the patient or his attendants.

In the management of wounds about the face, mouth, and throat, special care is necessary to prevent the offensive mucous and salivary secretions from passing into the stomach. The neglect of this precaution is liable to be followed by a low, typhoid state of the system, very similar to what occurs in pyemia, or blood-poisoning.

These effects are very common in bad cases of gunshot wounds of this region, and I have repeatedly had occasion to notice them after operations upon the jaws, mouth, and even the nose.

Another bad effect of these wounds is paralysis, partial or complete, of the face, from injury to the branches of the facial nerve. Loss of sensation will be experienced if there is severe contusion or division of the branches of the fifth pair.

The horrible and disfiguring gaps of the face consequent upon these lesions occasionally admit of closure by an autoplasmic operation, the flaps being borrowed from the neighboring surface, or partly from this and partly from the arm.

Neuralgia.—Neuralgia of the face is a very common occurrence, and often entails an almost insupportable amount of suffering, rendering life absolutely one of incessant torture. The intermittent form of the disease, depending upon malarious influences, generally very readily yields to quinine, morphia, arsenic, and strychnia, preceded by a mercurial purge, and accompanied by a proper regulation of the diet. The case is very different when the disease is occasioned by organic lesion of the nerve itself, as inflammation and deposits of plasma in its substance, or by compression by encroachment of the bony wall in which the affected cord is inclosed. Under such circumstances a cure can only be effected by thorough excision, an operation which has now been so often practised as to entitle it to be regarded as one of the established procedures in surgery. The two nerves requiring excision for neuralgia are the second and third branches of the fifth pair, which may suffer either separately or simultaneously, although the latter is uncommon.

For the relief of neuralgia of the superior maxillary nerve, resection of the affected cord has within the last fifteen years been pushed to a very bold but perfectly warrantable extent by several American surgeons, as Carnochan, Blackman, W. H. Mussey, and others, the first having taken the lead, and thus earned for himself great credit in a class of cases previously considered as incurable. The results of his cases, three in number, will be found in an interesting paper on the subject in the *American Journal of the Medical Sciences* for January, 1858. The procedure consisted in excising the trunk of the second branch of the fifth pair of nerves, beyond the ganglion of Meckel, on account of severe neuralgia of the face. The length of nerve removed, in two of the cases, was two inches; in the other, an inch and three-quarters. The effect in all was most gratifying. Equally happy results have attended the operation in the hands of Blackman, W. H. Mussey, and other surgeons. I have myself repeatedly performed it with immediate and permanent relief; but in no instance have I been compelled to carry the division as high up as the ganglion of Meckel.

Professor Conner, of Cincinnati, has collected thirteen cases in which this operation was executed, in seven of which the pain is known to have recurred, at a period varying from four weeks to sixteen months. Of the remaining six, in which a return of the affection has not been reported, the history is known, respectively, for twenty-eight days, two months, fourteen months, several months, several years, and the result of one at the time of the report was dubious. It would thus appear that the number of failures, or cases in which temporary relief alone was afforded, exceeds the cures, under which are included the instances in which the result of the operation has not been fully reported. We may, therefore, be warranted in concluding that the removal of the ganglion of Meckel is not essential, and that the more simple operation of neurectomy of the superior maxillary nerve as far back as it can be reached by the knife, may be substituted for it.

The operation of exposing the second branch of the fifth pair, as performed by Dr. Carnochan, is severe and complicated, and requires, besides chisels and bone-nippers, two trephines, one three-quarters of an inch in diameter, and the other half an inch; the latter being intended for perforating the posterior wall of the antrum. The patient, placed under the influence of chloroform, lies upon a table, with the head well supported by pillows, and firmly held by an assistant. The infraorbital foramen is then laid bare by two incisions, commencing above, near the inner and outer angles of the eye, at the inferior edge of the orbit, and terminating at a sharp point, about an inch below, opposite the furrow on the lower portion of the ala of the nose, the flap thus formed representing the shape of a V. The lip, being now everted, is next detached from the upper jaw, when it is completely divided, along with the cheek, by a vertical incision, extending from the inferior extremity

of the V-incision through its free border. By dissecting up the two large flaps thus marked out, turning one outward and the other inward, the whole of the front wall of the antrum, together with the trunk of the infraorbital nerve, is completely laid bare. The crown of the large trephine is now applied immediately below the foramen, and an irregular disk of bone removed, so as to expose the cavity of the antrum. The lower wall of the infraorbital canal is cut away with the pliers and chisel, while the posterior wall of the antrum is perforated with the smaller trephine. The trunk of the nerve is then isolated from the other tissues in the spheno-maxillary fossa, and carefully traced beyond the ganglion of Meckel, behind which, close to the round foramen in the sphenoid bone, it is divided from below upwards with a pair of blunt-pointed scissors, curved on the flat. The hemorrhage is slight, and the flow from the branches of the internal maxillary artery, in the spheno-maxillary fossa, is easily controlled with compressed sponge.

In performing this operation upon the dead subject, I have found it quite easy to obtain a sufficiency of room for exposing the nerve, in its entire length, by carrying a curvilinear incision, from an inch and a quarter to an inch and a half in extent, across the cheek, beginning a short distance below the inner angle of the eye, descending towards the level of the ala of the nose, and terminating a little beyond and below the outer angle of the eye. Whatever plan of incision be adopted, care must be taken not to inflict any unnecessary injury upon the osseous tissues, or to expose too freely the structures of the orbit.

The superior maxillary nerve may be excised without division of the lower wall of the infraorbital canal, by a subcutaneous operation devised by Professor Langenbeck. A stout tenotome is thrust, with its point directed backwards and downwards, immediately under the external palpebral ligament, and pushed along, in close contact with the outer wall of the orbit, until the spheno-maxillary fissure is reached, as denoted by the cessation of resistance. The edge of the knife is then turned somewhat inwards, so as to touch the orbital process of the superior maxilla, when it is carried forwards by a sawing motion, and the nerve divided just before its entrance into the infraorbital canal. A perpendicular incision, about half an inch long, is next carried downwards from the lower border of the orbit, and the infraorbital nerve raised on a blunt hook, and seized with a pair of broad, flat forceps. By a twisting motion it is readily drawn out, and is then separated from its connection with the soft parts of the cheek. Should the nerve not come away, the first stage of the operation must be repeated.

This procedure has been successfully practised by its originator, by Dr. Hahn, and by Dr. Hueter. The only unpleasant consequence attending it is extravasation of blood into the loose tissues of the orbit, from division of the infraorbital artery. The extravasation, however, in the reported cases was slight, and rapidly disappeared.

An ingenious operation for exposing the second and third branches of the fifth pair of nerves was devised, many years ago, by Professor Pancoast, and has been practised by him successfully in four cases, all attended with great and protracted suffering. The operation is one of unusual delicacy, demanding for its proper execution a thorough knowledge of the anatomy of the parts concerned.

A horizontal incision being made across the ramus of the lower jaw, in its entire length, its extremities are connected by two parallel, vertical cuts, extending up to the malar bone and the zygoma, care being taken in doing this to avoid injuring the duct of Steno. A trap-door flap, thus outlined, as in fig. 124, is then raised, and reflected upon the cheek, by shaving off the masseter muscle and other soft structures from the bone, including the coronoid process, which is next sawed off at its root, and detached from the temporal muscle. By pushing up this muscle under the zygoma, the spheno-maxillary fissure is fully exposed, revealing



Pancoast's Operation for Neuralgia.

at its bottom, after some fatty matter has been cleared away, the trunk of the internal maxillary artery, which is at once seized and ligatured.

The next step of the operation consists in detaching the upper head of the external pterygoid muscle from the ridge of the great wing of the sphenoid bone, in freely loosening with the finger any soft parts that may be in the way, and in stopping any oozing of blood that may exist with Pagliari's styptic, applied upon plugs of patent lint. The wound being thus enlarged and dried, all the nerves in the zygomatic fossa are plainly visible, as they branch off from the oval foramen, and may be successfully raised with the forceps, and divided, about half an inch of each being snipped off with the curved scissors. Generally a few little filaments issuing through the neighboring apertures are removed at the same time, thus increasing the chances of a radical cure.

To expose the second branch of the fifth pair as it crosses the spheno-maxillary fossa, the pterygo-maxillary fissure must be laid open by extending the incisions a little further upwards and inwards, as far as the external rectus muscle at the anterior lacerated foramen. The nerve is then encircled with a delicate, but very strong, well waxed ligature by means of a hook with a notch near its end. The thread is tied into a knot to secure a firm hold upon the nerve, a section of which, about one-third of an inch in length, is then removed, the knife being carried in close contact with the round foramen behind and the bones in front. The passage of the ligature is usually a very difficult step of the operation, and additional perplexity is experienced when, the pile of bones of the face being very small, the pterygo-maxillary fissure is uncommonly narrow and difficult of access. In one of his cases Professor Pancoast was obliged, on this account, to crush in a little of the posterior wall of the antrum.

The inferior branch of the fifth pair of nerves may be exposed by perforating the ramus of the lower jaw about three-quarters of an inch behind the large grinder, five-eighths of an inch above the angle of the bone, and an inch and a quarter below the zygomatic process of the temporal bone. A curvilinear incision, with the convexity downwards, is carried over the ramus, about two inches and a half in length, and, the flap thus made being dissected up and held out of the way, a disk of bone, half an inch in diameter, is removed with the trephine. The nerve is then raised with a blunt hook, and as much as can easily be got at removed with the scissors. Some hemorrhage necessarily follows the division of the dental artery, but this is usually readily arrested by the ligature or by compression.

The inferior dental nerve, at its exit from the jaw, will be found opposite the first bicuspid tooth, midway between the inferior border of the bone and its alveolar margin, and may be easily exposed by raising a semilunar flap of integument with the convexity towards the neck. Should it be deemed advisable to follow the nerve into the dental canal, this can readily be done by the use of the trephine.

Facial Paralysis.—When, from any cause, the portio dura, the nerve of expression, as it was long ago called by Sir Charles Bell, ceases to transmit its appropriate fluid, the muscles to which it is distributed are rendered powerless, constituting what is known as facial paralysis. The affection is generally unilateral, but cases occur, although they are very uncommon, in which it is symmetrical. The most frequent cause of the disease, so far as I have had occasion to observe it, is cold, applied to the head, as when a person lies in a draught of air. In many cases it is produced by the pressure of some morbid growth, as an enlarged parotid gland or an encephaloid tumor, by caries, necrosis or fracture of the petrous portion of the temporal bone, or by inflammatory deposits either under the neurilemma or within the substance of the nerve itself. Professor Flint has met with too instances in which it was due to anemia. The nerve is often divided in operations involving the deep structures of the parotid region. Bell gives a case in which the paralysis was produced by a pistol shot, the ball entering the ear, and tearing the nerve across at its root.

The symptoms are unequivocal. The affected side of the face is flaccid, immovable, expressionless, and, during laughter, drawn over towards the opposite side. The corner of the mouth is habitually lowered, and the patient is unable to close his eye, to wink, to frown, to whistle, to pronounce certain letters, and to expand the ala of the nose. The saliva is retained with difficulty, expectoration is imperfect, and mastication is troublesome from the accumulation of food between the teeth and the cheek. If an attempt be made to blow, the cheek will puff out like a loose bag. The soft palate sometimes participates in the paralysis, the arches being relaxed, and the

uvula deflected to one side. The disease, in rare cases, coexists with loss of sensation of the affected side, or one side may be deprived of motor power, and the other of feeling. Loss of taste on one side of the tongue is sometimes observed, as when the facial nerve is affected at its origin, or posterior to the detachment of the cord of the tympanum. Paralysis of one side of the tongue will be likely to exist when the hypoglossal nerve is involved in the mischief. Duchenne has shown that when the cause of the paralysis is intracranial the muscles of the face readily respond to the electrical stimulus, but not when it is situated externally.

When the paralysis affects both nerves, the countenance wears a sad, woe-begone expression; the eyes are constantly open; the saliva dribbles from the mouth; and articulation, mastication, and even deglutition are performed with difficulty. When the paralysis is complete, the breathing is sometimes notably embarrassed by the incurvation at each inspiration of the alæ of the nose. The palate in this condition almost invariably participates in the disease.

The prognosis in facial paralysis is influenced by circumstances. In the milder cases, coming on suddenly, as an effect of cold or a slight contusion, restoration is the rule, recovery usually occurring within a few weeks. When, on the contrary, the disease depends upon organic lesion of the brain, the ear or the temporal bone, the paralysis will be likely to be permanent. The double form is always, other things being equal, more unfavorable than the single or unilateral. When the paralysis is unusually obstinate, it may generally be assumed that it is due to serious structural, if not hopelessly incurable, lesion. I have met with several cases in young children in which the paralysis, without an appreciable cause, was permanent.

The treatment of paralysis of the face depending upon suspended function of the hard branch of the seventh pair of nerves must be regulated in strict accordance with the nature of the exciting cause. When the disease is the effect of cold, an active purgative, a few doses of Dover's powder, proper attention to the diet and secretions, and half a dozen leeches in front of the ear will generally suffice to effect a cure. When there is reason to believe that it has been caused by inflammatory deposits either around or within the nerve, a series of blisters, conjoined with the use of mercury, carried to rapid but gentle ptyalism, will be most likely to afford relief. When the case is obstinate, merging into chronicity, the most suitable remedies will be iodide of potassium, sorbefacient embrocations, electricity, the shower bath, and change of air. No plan of treatment, however judiciously devised or executed, can do any good when the disease depends upon organic lesion of the temporal bone or of the base of the brain.

Tumors.—Various kinds of morbid growths, benign as well as malignant, are liable to appear in the face, commencing either in the skin, in the cellular substance, or in the osseous tissues; but as they do not differ, in any essential particular, from similar diseases in other regions, they do not require any elaborate notice.

The *sebaceous* tumor, of which a sufficiently full account is given in the chapter on the diseases of the skin, is quite common in this region. It is easily distinguished by its tardy development, its mobility and freedom from pain, and by its soft, elastic consistence. Its shape is generally somewhat ovoidal, and its volume ranges from a pea up to that of an almond. The skin over it is usually perfectly healthy.

The *fibrous* tumor is occasionally, but very rarely, seen in this region, mostly directly over the antrum of Highmore. It is of a slow growth, firm in its consistence, capable of attaining a large bulk, and liable to recur after extirpation.

The *fatty* tumor of the face is met with chiefly in the upper eyelids and the forehead, in connection with which it will hereafter be described. Upon the cheeks, where it is very uncommon, I lately met with a case in a man, fifty-three years of age, the tumor being about the size of a small orange, and of a globular shape. The lips seem to be exempt from it.

The *cystic* tumor sometimes occurs in the face, generally, if not invariably, as a congenital vice. In a case of this kind, recently under my observation, the size of the tumor was enormous. It involved the greater part of the left side of the face and neck, extending, on the one hand, from above the ear to the clavicle, and, on the other, from the angle of the mouth and nose to the posterior border of the sternocleidomastoid muscle. The disfigurement was very great. A most extensive and tedious dissection was necessary; but, notwithstanding this, the child, who was only six weeks old, bore the operation well, and made a very rapid and complete recovery.

Cystic formations in this region are commonly multiple, the number of cells being sometimes very great; they are nearly always closely grouped, have thin, transparent walls, with serous contents, and vary in size from that of a millet seed up to that of a large marble. In cases of long standing, their walls and contents are liable to undergo various transformations, thus materially changing their original character. The only remedy is excision.

A peculiar form of cystic tumor, first accurately described by Verneuil, and due to hypertrophy of the sweat glands, with mucoid transformation of their epithelial cells, has been observed in the integument of the face, especially in that of the cheeks. It gives rise to a soft, elastic, indolent, slightly elevated swelling, which rarely exceeds the volume of a cherry. The skin is free from discoloration, and a clear fluid may occasionally be made to exude on pressure.

Aneurism by anastomosis, generally in the form of a congenital vice, not unfrequently occurs in the face, and requires the same kind of management as in other parts of the body. The great rule, when an attempt is made to remove such a growth by excision, is to carry the knife through the sound tissues, and not through its substance.

A purely *venous* tumor, or, more properly speaking, a *nævroid* growth, also generally congenital, is liable to appear on the face, and is easily and safely dealt with by excision, the operation, if proper care is taken, being almost bloodless, even when the growth is of inordinate bulk. The annexed sketch, fig. 125, represents a large

Fig. 125.



Fig. 126.



Venous Tumor of the Lip and Cheek.

growth of this kind, which I removed from the left side of the face and lip of a young lady, twenty-four years of age, with the loss of hardly three ounces of blood, although the operation necessarily involved the division of the coronary artery. The tumor had commenced early in life, and had greatly disfigured an otherwise very pretty face. During the excision, it literally shrunk away to nothing. Fig. 126 shows the result of the operation.

In the parotid region, it is not uncommon to find enlargements of the lymphatic glands, and various malignant affections, seated either in these bodies or in the substance of the parotid gland itself. To these, particular attention will be directed under their appropriate heads.

Elephantiasis of the face sometimes occurs, as in the remarkable case observed by Dr. Carnochan, in which he tied, after an interval of six months, both primitive carotid arteries, the patient being a woman, forty-four years of age. The disease covered in the whole of the cervico-facial region, along with the ears and a portion of the scalp, causing hideous deformity, with unnatural discoloration of the skin. The operations were followed by marked improvement, consisting of great shrinking of the mass; but when the case was reported, several years after the ligation of the vessels in question, the cure was still imperfect. A full account of the case will be found in the American Journal of the Medical Sciences for July, 1867.

Papillary tumors, in the form of warts and horn-like excrescences, often grow upon the face, where, besides their unseemly appearance, they are frequently a source of irritation and annoyance, apart from their liability, at least in some cases, to take on malignancy. As long as they are stationary, and not productive of inconvenience, they may be let alone, otherwise they should promptly be removed with the knife, ligature, or caustic.

A remarkable case of congenital *fœtal tumor* in a child, seven months old, was brought to the Clinic of the Jefferson Medical College, in 1859, where it was successfully removed by means of the *écraseur* by Professor Pancoast.

Fig. 127.



Congenital Fœtal Tumor.

The mass, which at birth was only about the size of an ordinary apple, was nearly ten inches in diameter by three and a half in thickness, globular in shape, and irregularly lobulated upon the surface, which presented at one point marks of a recently-formed abscess and at another a dimple-shaped depression, apparently corresponding with the attachment of an umbilical cord. It was provided with rudimentary extremities, as the adjoining sketch, fig. 127, shows, and was connected by a peculiar caul-like membrane, upwards of two inches in diameter, to the left cheek. One portion of the tumor pulsated distinctly, but not synchronously with the heart. The child being thoroughly etherized, an *écraseur* was applied, and worked rapidly until the pedicle was well compressed, and then very slowly, the whole procedure occupying about fifteen minutes. Hardly any blood was lost, and only one small artery required ligation. The wound left by the instrument was not quite two inches

in diameter. The tumor weighed nearly two pounds and a half. The dissection disclosed the existence of a rudimentary gastro-intestinal tract, eighteen inches long, and partially filled with meconium, a heart with imperfectly developed auricles and ventricles, a liver, large mesenteric arteries and veins, a number of pieces of bone representing the pelvis, and some spinal nerves with a large quantity of fatty matter, the whole mass looking very much like an ordinary lipoma. No bad effects followed the operation, except a fistule of the cheek, the result, apparently, of injury unavoidably inflicted upon the buccinator muscle, dragged into the pedicle of the tumor by the weight of the parasite. The subject of this extraordinary case is now thirteen years of age, with a scar not larger than the end of a finger at the site of the original deformity.

The *sarcomatous* tumor of the face is observed principally in elderly persons, and belongs essentially to the spindle-celled variety of the affection. Arising generally without any assignable cause, it is distinguished chiefly by the rapidity of its growth, its rounded form, its mobility, and the absence of pain, lymphatic involvement, enlargement of the subcutaneous veins, and tendency to ulceration. When it is developed from soft warts, however, its surface is occasionally excoriated and covered with granulations, thereby producing a resemblance to epithelioma. The proper treatment is early excision, although local return may be anticipated, particularly in the melanotic and myxomatous varieties of the affection.

A very remarkable case, in which multiple sarcomas of the face spontaneously disappeared in consequence of an attack of erysipelas, has been recorded by Pro-

fessor Busch, and is worthy of passing notice. The patient was a female, forty-three years of age, and the tumors, which were firm and varied in size from a hazelnut to a pigeon's egg, were seated on the nose, the glabella, and beneath the lids. A portion of the largest was removed, the operation being followed by violent erysipelas, under the influence of which the morbid growths became softer and were finally absorbed. Under such circumstances it is highly probable that the cells rapidly undergo the fatty transformation.

The only carcinomatous disease of the face requiring passing notice here is the *corroding lupus*, or epithelioma, of which the annexed sketch, fig. 128, from Druitt, affords an admirable illustration. Generally taking its rise in the form of a little fissure, superficial ulcer, or warty excrescence of the skin, it gradually extends in depth and circumference until at length it involves, in many cases, the entire face—integument, muscle, cartilage, and bone—leading thus to the most frightful suffering and deformity. The period at which death occurs varies, on an average, from eighteen months to four or five years. Now and then, although very rarely, the disease, after having committed extraordinary ravages, gradually stops, the parts cicatrize, and the morbid action never recurs. The treatment of corroding lupus has been sufficiently discussed in the chapter on cutaneous affections.

Broad and unsightly *cicatrices* of the face, especially such as are consequent upon burns and scalds, often admit of removal by a very simple operation, the vicious parts being included in two incisions, the edges of which are afterwards carefully approximated by suture. When the loss of original substance is very great, it must be supplied with integument borrowed from the neighborhood; and a similar procedure will be necessary when the cheek is the seat of large and unseemly chasms, occasioned by wounds or ulcers, as, for example, those consequent upon gangrenous ptyalism. The sketches in the chapter on the diseases of the jaws afford a good idea of the nature of such an operation.

Finally, in surgical operations upon this region, especially such as are necessary for the removal of various kinds of morbid growths, the incisions should be planned with reference to the least deformity. This is generally best done by carrying the knife in the direction of the folds of the skin, when any exist, or where they will be likely to occur as the patient grows older. The most unseemly and disfiguring cicatrices are, as a rule, those which follow perpendicular or very oblique incisions.

Much inconvenience is often experienced, both by the patient and the surgeon, in the more severe and extensive operations on the face, especially such as involve the upper jaw-bone, the antrum of Highmore, and the nasal cavities, from the escape of blood into the fauces and larynx. To prevent this occurrence, the best plan is to plug, as a preliminary step, the posterior nares, care being taken to remove the tampon as soon as the bleeding has ceased.

Fig. 128.



Corroding Lupus, or Epithelioma of the Face.

CHAPTER V.

DISEASES AND INJURIES OF THE EYE.

THE most important discovery of the present century, as an auxiliary to the study of the diseases of the eye, is the ophthalmoscope, a contrivance by the aid of which the background of this organ may be lighted up, and its delicate tissues clearly inspected. Of the many instruments of the kind now in use, that devised by Dr. Anagnostakis, of Athens, is perhaps the most simple, combining, as it does, great facility of application with portability and cheapness. At all events, it is, with some modifications, the one now most generally employed. It essentially consists of a convex lens, and of a concave, circular mirror, about two inches in diameter, perforated in the centre by a small hole, to the back of which is fitted a plate of blackened copper, the whole being inclosed in a brass ring and mounted upon a short handle.

During the examination, which must be made in a dark room, the mirror is held in one hand, and the lens close before the eye in the other. Unless this precaution be adopted, it will be impossible, in the great majority of cases, although the bottom of the organ may be highly illuminated, to obtain a distinct view of any of its individual parts. The pupil may be dilated with atropia, in the proportion of one grain to the ounce of water, a small quantity of which is applied to the eye half an hour before.

The surgeon and the patient sit immediately opposite to each other, near a table furnished with a bright lamp, or, what is better, an argand burner, placed just behind the patient's ear, as in fig 129. The speculum is held in the right hand, in such a

Fig. 129.



Mode of Conducting an Ophthalmoscopic Examination.

manner as to throw the light from the lamp into the affected organ. The observer then looks through the hole in the instrument, and approaches or recedes from the patient's face, keeping the flame all the while steadily upon the eye, until he sees the pupil appear of a bright-red color. The double convex lens, held between the thumb and index finger of the left hand, is then brought close to the affected organ, when, by slowly moving the mirror back and forth, he can soon find the proper focal

distance, and readily see a distinct bloodvessel, as well as other objects, at the bottom of the eye. This distance should be as firmly maintained as possible, and the vessel followed to its entrance into the optic papilla. This is done either by moving the mirror slowly from side to side, or, what is better, by moving the lens slightly in a similar way, bearing in mind the fact that the objects at the bottom of the eye move in the opposite direction from the lens. The optic papilla should be the first point sought for and will come into view in the left eye of the patient when he fixes his gaze upon the right ear, and in the right eye when he looks at the left ear, of the surgeon; afterwards the observer may examine the adjacent parts of the retina and choroid as far forward even as the ora serrata. The papilla, fig. 130, is seen as a brilliant, well defined, yellowish-white spot, usually circular in form, and contrasting strongly with the neighboring parts of the retina, which appear of a light pinkish color. Either in the middle of this spot, or a little to one side, are the central artery and vein of the retina, each having two branches, one ascending and the other descending, while several smaller ones extend outwardly. By looking steadily at these vessels, while slight pressure is made with the finger on the ball, they will be found to beat distinctly and synchronously with the pulse at the wrist.

The convex lens thus placed in front of the eye forms an inverted aerial image of the eye-ground, between the lens and the eye of the observer; and this is known as the indirect method of examination.

When greater accuracy is needed, the direct method should be employed, by which the disc will appear to be about five times larger; and very slight changes in the eye-ground may be better appreciated.

The surgeon illuminates the interior of the eye with the mirror, and, placing himself with his own eye at a distance of two or three inches from that of the patient, he uses the cornea and lens of the patient's eye as a magnifying apparatus, with which to examine the details of its eye-ground. Should the patient, or the observer, suffer from any optical defect, as, for example, myopia, a concave lens of sufficient power must be placed by the surgeon in front of his own eye, but behind the mirror.

The ophthalmoscope of Liebreich is now extensively employed, since it permits the use of either the direct or indirect method. It consists of a concave mirror one and a half inches in diameter and six inches in focal length, having a central aperture of one-tenth of an inch. Behind the mirror is a hinged clip in which may be placed the small convex or concave lenses requisite for the direct examination. For the indirect examination it is provided with two biconvex lenses of two and three inches in focus, as seen in fig. 131.

The ophthalmoscope of Dr. Loring, of New York, is the most complete in its arrangements, and is so constructed as to contain the requisite convex and concave lenses, from three to forty-eight inches in focal length, in metallic discs which are placed behind the mirror; and their rotation enables the surgeon to select, with but little delay, the lens with which he can see clearly the minute details of the eye-ground under inspection.

The optic *papilla* is variously changed by disease. Among the milder affections, the most frequent is hyperemia, or congestion, the result of disease, or of excessive and long-continued fatigue of the eye, so common in seamstresses, engravers, watch-makers, proof-readers, and compositors. It is characterized by a dilated condition of the vessels of the retina, which is sometimes so great as almost to conceal the papilla.

One of the most important morbid alterations which the optic papilla experiences is an umbilical depression, with perceptible pulsations of the

Fig. 130.



Healthy Appearance of the Eye.

Fig. 131.



Liebreich's Ophthalmoscope.

vessels, sometimes seen in glaucoma. The phenomenon, however, which is probably due to intraocular pressure, is usually not detected in this affection until a late period. It is occasionally conjoined with textural changes in the adjacent portion of the retina, and the papilla is then liable to lose its distinctive appearance, becoming insensibly lost in the surrounding parts. In inflammation of the retina, both this membrane and the optic papilla are preternaturally vascular, and not unfrequently the seat of plastic deposits, superficial as well as interstitial, ecchymoses, and other alterations, as exhibited in figs. 132 and 133. Sometimes the retina is partially detached from the choroid by dropsical accumulations, presenting themselves in the form of bluish-white, undulating bags, projecting forwards into the vitreous humor.

Fig. 132.



Inflammatory Deposits on the Retina.

Fig. 133.



Extravasations of Blood on the Retina.

Inflammation of the *choroid*, with exudation and subsequent atrophy of that membrane, and absorption of its pigment, as in the condition called posterior sclerotic-choroiditis, is characterized by the appearance of brilliant white, irregular spots, produced by the strong reflection from the sclerotica. The cellular cysticercæ, a peculiar form of entozoon, is occasionally found in the retina between this membrane and the choroid, and in the vitreous humor. The macula lutea, or yellow spot, should always be examined, since it is often the seat of morbid changes fatal to vision; it may be seen when the patient looks at the central perforation of the mirror.

The most common pathological changes in the *vitreous humor* are liquefaction of its substance with diffused turbidness, and brownish shreds, or corpuscles, of various shapes and sizes, floating in it, mounting up into view when the eye is moved, and subsiding to the bottom of the organ when it is held still. These are either masses of lymph that have been detached from the retina, choroid, or ciliary body, the remains of blood that has been poured out into the eye, or, perhaps, portions of the disorganized hyaloid membrane. These changes of the vitreous body are nearly always attended with serious disease of the retina, but it is often impossible to distinguish this membrane through the opaque substance. Such floating bodies are very readily detected by the ophthalmoscope when used in the direct method.

The speculum is a useful means also for determining the degree of opacity of the crystalline lens in cataract, and for the diagnosis of the different varieties of that disease. Incipient and slight opacities of that organ, which elude the most careful examination with the unassisted eye, are sometimes easily detected with this instrument. They appear as a brownish, grayish, or drab-colored veil, or as streaks across the red background of the eye. A weak light is preferable to a strong illumination, and opacities are more readily detected by looking obliquely into the pupil, when they usually appear of a grayish color.

These are but a few of the pathological changes in the back part of the eye, which may be brought to light by the ophthalmoscope. A detailed description of them all would be incompatible with the limits of this section. They are, however, sufficient to establish its indispensable importance, in the discrimination of those numerous diseases which were formerly all grouped together, under the general name of amaurosis. It need hardly be added that it requires much patience and practice with the instrument to give one that tact in the use of it so necessary to precision of diagnosis.

Lateral or oblique illumination enables the examination of the anterior portion of the eye to be made with precision. It should be conducted in a darkened room, by the aid of a lamp placed at the side and in front of the patient. The surgeon, with a convex lens of two inches focus, held near to the patient's cornea, condenses upon it a fine pencil of rays, and thus explores the anterior portion of the globe. He may aid his vision by using an additional convex lens in front of his own eye, and may then perceive very slight changes in the cornea, iris, anterior chamber, or crystalline lens. This method will be understood by a glance at the woodcut, fig. 134, and will be found almost indispensable in the discrimination of doubtful cases of iritis and cataract.

Fig. 134.



Lateral Illumination of the Eye.

Ocular Inspection.—In examining this organ with the unassisted eye, the patient should sit upon a chair, in a good light, unless there is severe inflammation, when he must sit with his back towards it. The upper lid may be gently elevated by means of the index finger, the point of which is placed against its free border, or with an instrument specially constructed for the purpose, as one of those represented in figs. 135 and 136. The lower lid is easily depressed with the finger applied to the margin of the orbit; a procedure which, at the same time, freely exposes its inner surface. Eversion of the upper lid is effected by means of a probe, director, or pencil, placed

Fig. 135.



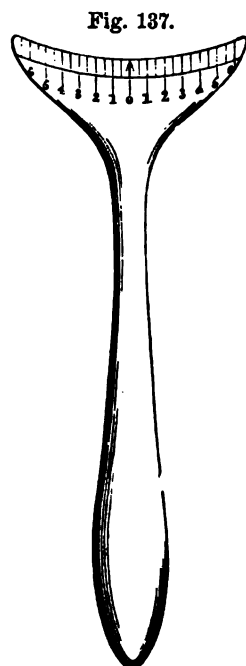
Fig. 136.



Different forms of Elevators.

horizontally along the upper margin of the tarsal cartilage, and gently pressed against the surface, while the surgeon, standing behind or in front of the patient, raises the free margin of the lid by the cilia, with the thumb and forefinger.

The observer must be careful, in his inspections, not to mistake for disease of the eye the discoloration of its tissues from the long-continued and improper use of nitrate of silver. The stain which is thus produced, and which is particularly conspicuous in the sclerotica and in the mucous lining of the lids, is of a dusky, greenish, or dirty sepia tint, and is sometimes so great as to deprive the eye not only of its natural lustre, but to cause very serious disfigurement.



The mobility of the eye-ball is determined by directing the patient to follow the movements of the index finger, which the surgeon holds near to the face, and moves about in various directions. In cases of strabismus, where it may be desirable to measure accurately the deviation inwards or outwards, the strabismometer, fig. 137, may be used. It consists of an ivory plate, moulded so as to conform to the lower eye-lid, having upon its free border a scale, divided into lines and half lines. The patient regards a distant object whilst the instrument is placed upon the lower lid, the two accurately corresponding. The vertical diameter of the pupil will be opposite to 0 when the cornea is central. When inversion or eversion is observed, its degree may be measured by means of the scale, and the deviation in lines accurately determined.

The degree of intraocular tension, so important in the diagnosis of glaucoma, is ascertained by directing the patient to look downwards, and lightly to close his lids. The index finger of one hand is then applied to the eye-ball in such a manner as to make it steady, whilst with the other index finger the surgeon makes slight pressure, and ascertains whether the ball is of stony hardness, is easily dimpled,

or offers less than the normal amount of resistance.

Field of Vision.—It often becomes necessary to determine with accuracy the condition and extent of the visual field. To do this the patient is placed before the surgeon, at a distance of eighteen inches, and is directed to look with the eye under examination, after closing the other, into one eye of the surgeon, and to keep it steadily fixed. The surgeon now moves one hand in different directions, upward, downward, and laterally, throughout the field of vision, and thus ascertains how far from the optic axis it can be perceived with sufficient distinctness to enable the fingers to be counted. Any limitation of its normal extent, or its entire absence in any direction, may thus be readily determined.

When greater accuracy is desired, as in glaucoma, separation of the retina, and other affections, the patient may be placed eighteen inches from a black-board, or a sheet of black paper, and directed to keep his gaze fixed upon a small cross made in its centre with chalk. A piece of chalk, fixed into a dark handle, may then be brought from the periphery of the field towards the cross, and when it is first seen, the spot may be marked. After repeating this procedure throughout the entire field, the spots thus marked may be connected by a line, and a diagram of the entire visual field be obtained. To ascertain the visual power, or the acuteness of vision, the test types of Snellen will fulfil the purpose best.

Belladonna causes temporary dilatation and immobility of the pupil, and paralysis of the ciliary muscle. It is, therefore, a valuable agent in the treatment of most of the injuries and diseases of the eye, since, by its means, a degree of physiological rest is obtained for the organ. Its alkaloid, atropia, in the form of sulphate, is generally employed, and may be used in solution of four grains to the ounce of water, when we desire to paralyze the ciliary muscle, or to expand the pupil to its greatest extent, in order to obviate its closure in cases of iritis. When the object merely is to make an ophthalmoscopic examination, the requisite dilatation may readily be obtained by pouring upon the eye a few drops of a solution of one-fourth of a grain to an ounce of water.

The contraction of the pupil, and stimulation of the ciliary muscle, may be induced by the topical application of a solution of Calabar bean. The contraction begins in ten minutes, is confined to the eye treated, and continues for three days. It

is most conveniently used by dissolving three grains of the alcoholic extract in one drachm each of glycerine and water, a few drops of which may be placed within the lids.

Both atropia and Calabar bean cause great confusion of vision, by affecting, in an opposite manner, the optical condition of the eye. Patients should be informed of these effects, and of their evanescent character. Their antagonism enables us also to use the one, in a great measure, as the antidote to the other, in their local effects on the eyes. It is worthy of note that the topical use of atropia occasionally causes unpleasant nervous symptoms, as muscular tremors, numbness, and even delirium, as from an overdose exhibited internally. These effects, of which several instances have come under my personal observation, are generally readily relieved by an ordinary dose, or subcutaneous injection, of morphia. The application of the extract of belladonna is, also, sometimes followed by bad symptoms, especially in children and very nervous persons. I have heard of two infants, laboring under congenital cataract, being destroyed by wearing a belladonna plaster upon the forehead and temple.

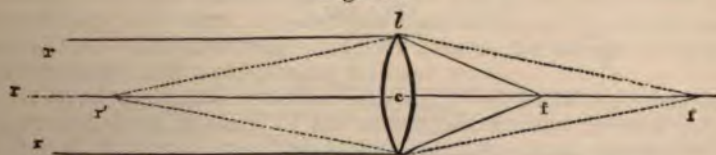
In cases of inflammation of the eye, and after all important operations upon this organ, the light should be carefully excluded from the patient's apartment, as the smallest quantity falling upon the retina generally proves hurtful. Sometimes the light requires to be merely moderated, and then the object may readily be attained by the use of a green shade, of a semilunar shape, made of thin pasteboard, covered with silk, and secured to the head by means of tapes tied at the occiput. After operations on the eye, especially those for cataract and artificial pupil, the organ must always be completely screened from the light, by closing the lids, placing upon them a piece of fine linen, and over this, fine carded cotton, or charpie, in sufficient quantity to fill up the inequalities of the orbit, and afford, with the superimposed bandage, a firm but gentle pressure. This should be retained in place by a roller of flannel two inches in width. Sometimes we are obliged to close the lids carefully with adhesive strips, or strips of isinglass plaster, especially after wounds of the cornea.

ANOMALIES OF REFRACTION AND DISEASES OF ACCOMMODATION.

An acquaintance with a few of the simple laws of light, so far as they concern the physiology of vision, will be found essential in using the ophthalmoscope in the direct method, and in making an exclusive diagnosis of a majority of the diseases and defects of the eye. Light may be transmitted through the media of an eye which are perfectly transparent, and may be received by a retina normal in structure, and conducted to a brain free from any lesion, and yet vision may be so imperfect as to be practically useless, by reason of some imperfection in the eye as an optical instrument; a defect which may, perhaps, be fully corrected by proper glasses.

The light from any object which falls upon a convex lens is bent by its curved surfaces, and brought to a focus, where a minute and inverted image of the object is produced. Upon this principle is constructed the camera obscura, composed of a box blackened within, a lens or lenses to condense the light, and a screen of ground glass to receive and make visible the image. Nothing short of a few experiments with such an instrument, which may easily be made with that used by the photographer, will convince one of the accuracy with which the screen must be adjusted in its distance from the lens, so that a sharply defined picture of objects before the lens may be made visible upon the ground-glass. When objects more than twenty feet distant are examined, the screen must be placed at the burning point of the lens, or at its principal focus; but, when images of nearer objects are projected

Fig. 138.



upon the ground-glass, it must be moved farther from the lens; and the extent of the displacement will depend upon the proximity of the object. Distant objects,

then, are displayed at the principal focus of the refractor, but for near objects an adjustment becomes necessary, and the images are found at one of the conjugate foci. This is explained by the preceding diagram, fig. 138: l represents a convex lens of six inches focus, upon which fall the two rays $r r$ from an object sufficiently remote to afford parallel rays; these are refracted by the curved surfaces and brought to a point of convergence, f , which is called the principal focus. Should the object be placed near to the lens, so as to afford divergent rays, at $r r'$ for example, the convergence will be removed to f' , where its image will be formed.

When, then, it is considered that the human eye is composed of curved surfaces—the cornea and crystalline lens—of a dense sclerotic coat which gives it form, of the black pigment-layer of the choroid, and of the receptive or sensitive retina, its resemblance to the optical instrument above mentioned is so perfect that we feel that the same laws must apply to both; and that objects are seen distinctly when these curved surfaces bend the light which falls upon them, and project upon the sentient layer of the retina their minute inverted images. The refraction of an eye, then, is said to be normal, and the eye emmetropic, when its retina is placed at that point where the images of distant objects fall upon it with accurate precision; and such an eye would suffer in visual power by any convex or concave glass placed before it.

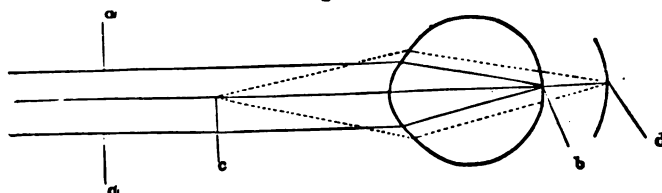
The necessity for changing the position of the ground-glass in the camera obscura, when a near object is focussed upon, and our own perceptions when we look from a distant to a near point, indicate that the human eye must also have some power of adjustment. This is called the power of accommodation, and must not be confounded with the refraction. Not being provided with a means of increasing the distance between the cornea and the retina, all near objects would be seen with great confusion, were it not that the eye is able to increase the power of its refractors, and thus bring the light which arises from a near point to a focus upon the retina. This is accomplished by the contraction of the ciliary muscle, whereby the crystalline lens becomes more convex in form, and thereby changes the optical state of the eye, as it might also be altered by placing before it a convex glass.

When the retina is not placed at the principal focal point of the refractors, we have a condition known as ametropia, characterized by imperfect vision for distant objects, when the eye is at rest. The axis of the eye from the apex of the cornea to the retina may be too short, when we have the condition known as hypermetropia, or it may be too long and give rise to myopia. From a want of symmetry in the curves of the cornea, an eye may be able to perceive lines which pass in a certain direction only, or the refraction may vary in its meridians so that hypermetropia and myopia may be present even in the same eye. This condition is known as astigmatism, and requires careful correction for its relief.

For the diagnosis and correction of these defects, test glasses, of known focal length, are generally employed in conjunction with test types, those of Snellen being preferred, which are so constructed as to present to the eye letters which subtend an angle of five minutes, at the distances at which they are to be placed from the patient. These letters vary in size from those which should be recognized at one foot, to that which can be seen at two hundred feet. When these test types are not at hand, any letters, one inch in length, may be used for a distance of fifty feet, and smaller ones, in the same ratio, for shorter distances. The ophthalmoscope, by direct examination, conjoined with test glasses, may be used to ascertain the refraction; or, an instrument, very simple and portable, devised by Dr. Thomson, and described in the American Journal of the Medical Sciences, for October, 1870.

The power of ACCOMMODATION enables the eye to bring to a focus upon its retina the rays of light that arise from near objects, which, without this function, would have their foci behind the retina, as in fig. 139.

Fig. 139.



The figure represents an emmetropic eye, with parallel rays falling upon the cornea and converging upon its retina, and is hence able to see distant objects distinctly. Should an object be placed twelve inches distant from it as at *c*, rays of light therefrom would fall upon the cornea divergent, and would have their focal point at *d*, where, if it were possible to place the retina, vision would be perfect. To bring this point forward to the retina might be accomplished by placing in front of the eye a convex glass of twelve-inch focus, or by such a contraction of the ciliary muscle as would increase the convexity of the crystalline lens, and augment its refracting power to the same degree.

This most important function depends upon the craving which we possess for perfect definition, and is exercised almost involuntarily whenever we regard any near object. It gives us the same optical power that would be produced could we add a convex glass to the crystalline lens. To ascertain its power, numerically, we must know the distance to the far point designated, *R*, and to the near point,

P, when $A = \frac{1}{P} - \frac{1}{R}$ gives the requisite formula. For example, an eye sees distinctly to the greatest distance, but its near point, as tested by small type, is at eight inches. The *A* would then be $\frac{1}{8} - \frac{1}{\infty}$, using this for infinity, $= \frac{1}{8}$, and the eye would possess the power of placing in itself an auxiliary lens equal to one of eight inches in focus.

Paralysis of accommodation may ensue upon injuries or diseases which involve the third pair of nerves; or may be consequent upon diphtheria, or other severe and exhausting ailments. It is most conveniently studied as artificially produced by solutions of atropia, when a normal eye may have perfect vision for distance, but no sharp definition for objects nearer than eight or ten feet; it may have vision again at the focal distance of any given convex lens, one of twelve inches for example, which restores vision perfectly for a page twelve inches distant.

Spasm of accommodation is often observed as the result of blows, or injuries, and is diagnosed by the presence of apparent myopia, caused by the lens preserving an optical power which enables the patient to see distinctly at some given point, but not beyond it: it may be produced by the instillation of Calabar bean, which not only contracts the pupil, but also causes this optical condition, and should be treated by the persistent use of atropia.

A partial loss of accommodation is a constant attendant upon increasing years, and causes the condition known as presbyopia, or old sight, in eyes both perfect and imperfect in refraction. A child is able to see small objects at three inches from its cornea; but as time passes, this power diminishes until the near point has so greatly receded that vision becomes very difficult for small objects.

PRESBYOPIA is said to begin when the near point has passed beyond eight inches; and it then makes itself manifest by a difficulty in distinguishing letters that resemble each other, or by an impossibility to thread a needle, or do other acts which demand acute vision. This condition is remedied by a convex glass, and it should be used as soon as any trouble is felt.

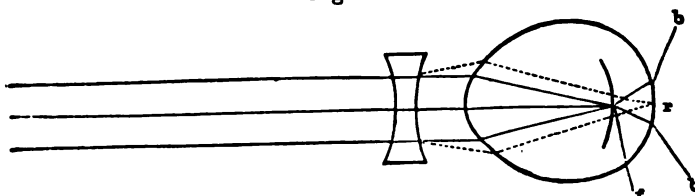
Let it be supposed that a person fifty years old is examined, and he is able to read a page of type beyond, but not within, sixteen inches—his near point is then 16'', and, if he sees distant objects perfectly, he has an $A = \frac{1}{16}$. To enable him to place his page at 8'', where presbyopia is assumed to begin, we subtract the near point from $\frac{1}{8}$, and find that $\frac{1}{8} - \frac{1}{16} = \frac{1}{16}$, which is the degree of the presbyopia, and that a convex $\frac{1}{16}$ gives him the power to see distinctly at eight inches. The selection of a glass for old sight is, however, subject to other influences, and that glass should be chosen which enables the patient to see his work best at the distance at which he has been accustomed to do it; and it must be borne in mind that a glass of 16 inches focus on a normal eye, limits the distant vision to that point, and makes all objects further removed very indistinct. Presbyopia complicates optical defects, and must be considered in their correction; and it is not unusual for an eye to require a concave glass for distance, and a convex one for near work.

APHAKIA, or absence of the crystalline lens, may be congenital, or may be a result of traumatic injury, or of any one of the operations for the removal of cataract. The highest degrees of hypermetropia are found in these cases together with an entire want of power of accommodation. To correct such a defect, the patient should be placed twenty feet from the test letters, or from a point of light, and that convex glass which gives the best definition should be sought for. The perforated screen,

described hereafter, is especially useful in these cases, and the glass which fuses the two lights will give the best visual power. Let it be supposed that $\frac{1}{2}$ has been selected for distance, and that the object is to know what glass will enable the man to read at 12 inches: add $\frac{1}{2} + \frac{1}{12}$ and we have $\frac{13}{12} = \frac{1}{\frac{12}{13}}$, which will give the same visual power at one foot which $\frac{1}{2}$ did at twenty. Although there is no accommodation in such an eye, yet the patient should be instructed that by moving the glass farther from the eye, down upon his nose, he will thus give himself a limited power of adjustment. Two glasses, however, will always be needed, one for distant, the other for near vision.

MYOPIA is due to an elongation, more particularly, of the posterior half of the eye-ball, by which the retina is removed from the principal focal point, f , and does not

Fig. 140.



receive perfect images of remote objects, but circles of diffusion $b b$. The effect of a suitable concave glass which removes f to r is shown by the dotted lines.

Although myopia is occasionally congenital and hereditary, yet it must be regarded as the result of prolonged use of the eyes upon near objects, with insufficient illumination, and in a constrained posture. Having fairly been induced, it has a tendency to become "progressive," and to be accompanied by changes in the choroid and retina, which not only greatly impair vision, but place it in jeopardy of being entirely destroyed.

It may be recognized by the greater visual power for near than distant objects; and by the fact that, however indistinct, the test letters may appear at twenty feet, yet at some point near the eye small type may be easily read. This point where confusion begins must be sought for, and its distance measured from the eye, since the determination of the r , or far point, gives a close approximation to the degree of the myopia. Let it be supposed that it is found at 12 inches, and that there the person can read small type; the degree of myopia may be said to be $\frac{1}{12}$, and a concave glass of this power will give equal vision for twenty feet, or extreme distance. This must be considered merely as an approximation, since with a convergence to a point 12 inches distant, there is always an amount of accommodation employed, which must not be corrected by the concave glass. Bearing this in mind, the rule is to select the weakest concave that will enable the person to see distinctly at twenty feet.

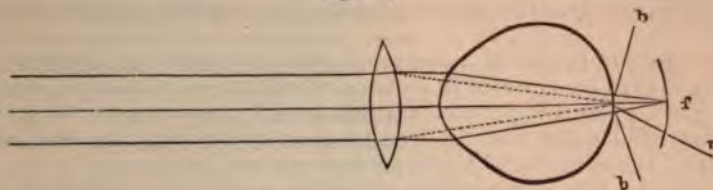
In high degrees of this defect, it is impracticable to give fully correcting glasses for reading purposes, since such persons are generally unaccustomed to use their full power of accommodation: moreover, concave glasses diminish the objects materially in size. With a myopia of $\frac{1}{6}$, for example, the person may need $-\frac{1}{6}$ for distance, but may find it impossible to read with it; and great fatigue may result from the attempt to do work without any concave glass at 6 inches, owing to the extreme convergence of both eye-balls, requisite to preserve single vision. It may, therefore, be desirable to place the far point, not at infinity, but at a distance that may enable music to be seen distinctly, for instance, at 18 inches. The proper glass is found by subtracting $\frac{1}{6} - \frac{1}{18} = \frac{1}{9} = \frac{1}{10.8}$, and with $-\frac{1}{9}$ this result will be attained. In like manner the far point may be placed wherever circumstances may seem to require it to be. Having ascertained the refraction, and the glass that gives the best distant vision, the range of accommodation must be determined as in an emmetropic eye, and any existing presbyopia corrected, either by the use of a weaker concave, or, as may occasionally be required, even by the selection of a convex glass to bring the near point to 8 inches.

High degrees of myopia are often attended with insufficiency of the internal straight muscles, and frequently with divergent strabismus, both resulting from the prolonged and forced convergence of the optic axes upon a point a few inches only from the

eye. These cases require careful correction, since operations undertaken for the strabismus without it are generally unsuccessful.

HYPERMETROPIA is the name by which is distinguished the optical defect found in an eye whose axis is too short, and whose retina is placed in front of the focal point for parallel rays, f . The images, therefore, of distant objects fall upon the retina in

Fig. 141.



circles of diffusion, $b b$, as indicated by the diagram, and are indistinct. By comparing this illustration with that used for demonstrating the power of accommodation, it will be observed that the hypermetropic eye fails to receive the images of distant objects upon its retina, as does the emmetropic eye those of near objects. The action of a convex glass in advancing the focal point is shown by the dotted lines, but a similar result in hypermetropia is produced by the use of the accommodation. From this fact, then, that distant vision may be obtained by the constant tension of the ciliary muscle, hypermetropia was not, until recently, so fully recognized as the opposite defect, myopia, although its evil effects are greater than those induced by the latter. It is the cause of those numerous symptoms that are ascribed to "weak eyes;" and will generally be found in persons who are unable to continue any near work, without a very painful effort.

Owing to the association between the power of accommodation, and that of convergence, a limited portion only of the former can be employed, without introducing, also, the latter; and this fact has led to the classification of hypermetropia into three grades, facultative, relative, and absolute.

In the first, the defect is slight and easily overcome by accommodation, so that the patient sees distant objects either with or without a convex glass, and can read small type; presbyopia, however, appears early. In the second form, the degree of hypermetropia is so great that, when sufficient accommodation is used to overcome it, undue convergence attends also, and objects appear double. It is in this form that internal strabismus is encountered; to it are due a great majority of the cases of internal squint; and to the failure to correct the hypermetropia may be ascribed the return of the deformity, after the division of the internal straight muscle. In the third form, the degree of hypermetropia is greater than the power of accommodation, so that even with the strongest convergence, the patient is unable to bring the images to a sharp definition upon the retina, and there is no perfect vision either for near or distant objects, with the unaided eye.

The fatigue which ensues upon the use of the eyes in sewing, reading, writing, and other pursuits, is the most prominent symptom, but it is generally accompanied by pain, heat, and redness; the media remain transparent, and the ophthalmoscope reveals nothing farther than slight hyperemia of the retina and optic disc.

The diagnosis is made by ascertaining whether the patient can see distinctly distant objects through a convex lens, bearing in mind that the weakest convex will sensibly impair the vision in an emmetropic eye. The optometer, hereafter described, furnishes a rapid method of diagnosis, or the ophthalmoscope in the "direct method," aided by convex lenses, may be employed.

The impossibility of fully relaxing the ciliary muscle in ordinary cases, has led to the division of hypermetropia into the manifest, and latent. The first is that degree of defect which is indicated by the focal length of the strongest convex glass through which the patient can see distant objects with precision. Should the ciliary muscle then be paralyzed temporarily by atropia, a still more powerful glass will probably be required to give perfect sight, and the strength of this second glass indicates the degree of latent hypermetropia. These examinations should be made with test letters, at a distance of twenty feet, with convex glasses of known focal length; the treatment consisting in a properly selected pair of glasses.

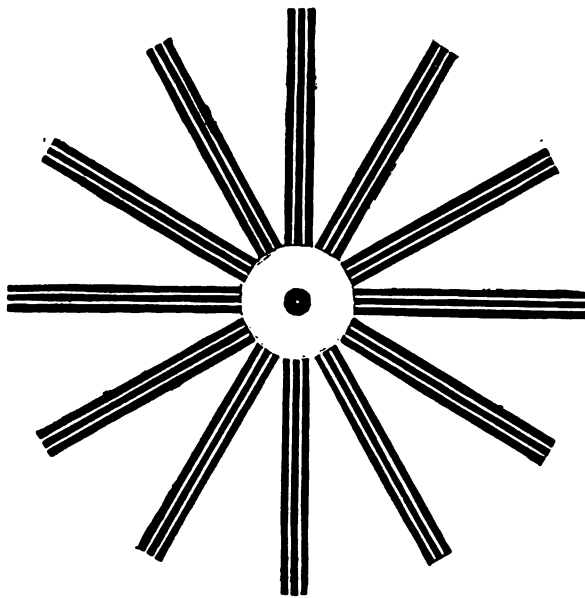
For the facultative form, no glasses for distance will be needed, but if there be asthenopia, those which are slightly stronger than the manifest degree may be ordered for reading. For the relative and absolute forms, spectacles should be worn, both for near and distant use, and in young persons we may commence with those which neutralize the manifest, and exchange them for stronger ones from time to time, until the degree of total hypermetropia has been corrected, bearing in mind that the fullest relief is to be ultimately attained by the use of the latter glass; or we may use atropia, paralyze the accommodation, and ascertain at once the degree of total defect.

It may be requisite to correct a degree of presbyopia also in a hypermetropic eye, and this may always be expected in persons over forty years of age. Having ascertained the glass which fully overcomes the total hypermetropia, the presbyopia is treated as described under that head, and a glass ordered for near work which shall be the result of the addition of the hypermetropia and presbyopia.

ASTIGMATISM is a form of ametropia, caused by a want of symmetry in the curves of the cornea, which produces a difference in the refraction of the eye in its different meridians, so that in the same eye there may be myopia in one, and hypermetropia or emmetropia in another meridian. The symptoms are reduced visual power, and the ability to see with precision only those lines on an object, that lie in a certain direction. In a brick wall, for example, the horizontal lines only may be distinguished; or, on viewing a picture upon a wall, the sides of the frame may be seen, whilst the top and bottom are very indistinct. A simple test is furnished by a small circular perforation in a screen through which light is transmitted, before which the patient should be placed, at a distance of sixteen feet. If astigmatism be present, the circle will appear elongated in some one or other direction.

The test objects proposed by Dr. Green are the best, and are constructed of lines which are of the same width as the letters Snellen's XX, arranged as in fig. 142, and

Fig. 142.



Green's Test Objects.

placed upon a card made to resemble the face of a clock. At twenty feet but one line may be seen, and the refraction of the eye should be examined by convex and concave glasses for it alone, and any possible myopia or hypermetropia determined; the line at right angles to the first one, will usually be found the most defective, and the patient's attention having been fixed upon it alone, the glass with which it can best be distinguished must be selected. The use of atropia will generally be found necessary in difficult cases, and should be employed without hesitation.

Should the eye be found emmetropic in one meridian, and myopic in another, as tested with these lines and ordinary spherical glasses, it will require a concave cylindrical glass of the proper focal

power, so placed before the eye as to affect only the defective meridian; and the strength of this glass will indicate the degree of astigmatism. It may happen that there is myopia in one meridian, and greater myopia in another, and that the correcting glass may have to be ground especially. The difference between them indicates the degree of myopic astigmatism, which must be corrected by a concave cylinder, ground on one side of a piece of glass, on the other side of which may be ground a concave spherical surface to correct only the general myopia.

For the details of this subject the reader is referred to the special text books, but

it may be remembered, that astigmatism is only a form of the two defects described already, and that the various meridians of the same eye must be separately analyzed and corrected, which may be accomplished by proper convex or concave cylindrical, or combined cylindrical and spherical glasses. The visual power is greatly diminished in high degrees of this defect, and its proper correction gives very brilliant and gratifying results. Presbyopia may remain to be considered, after the best correction for distance has been obtained; and here the same principles should guide us as in emmetropic eyes, assuming that a corrected astigmatic eye is in the same optical condition.

Astigmatism is generally congenital, but may follow operations or wounds of the cornea; and mixed astigmatism, a frequent result of pressure upon this membrane by granular lids, or of ulceration, is not capable of correction by cylinder glasses, but can be treated best by the use of a stenopaic apparatus, consisting of a screen with a narrow slit, or small circular perforation in it, mounted as a pair of spectacles.

A difference in the refraction of the two eyes is frequently encountered, and it may be considered very desirable to afford the patient binocular vision. They should both be carefully corrected, and the attempt made to use them together. Where there is a great difference between them, the effort will generally fail, from the inability to conjoin the images, dissimilar in size, that are cast upon the two retinae. The full correction of the least ametropic eye, and the same glass on the other, generally affords the greatest relief.

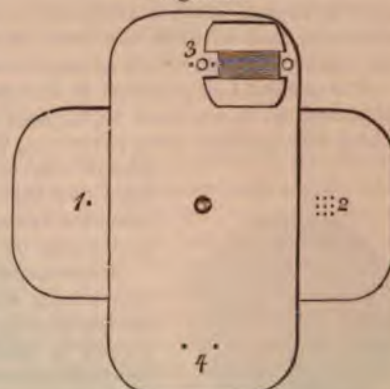
These examinations are much simplified by the use of an *optometer*, devised by Dr. Thomson, the principles of which should be remembered, since, with a visiting card and a pin, a rapid and efficient means of diagnosing the refractive condition of the eye may be obtained. The optometer, as seen in fig. 143, consists of four screens of thin brass perforated as follows:—

- No. 1. One hole, 1 millimetre diameter.
- " 2. Nine holes, $\frac{1}{2}$ " " "
- " 3. Two holes, 3 millimetres apart, $\frac{1}{2}$ millimetre diameter.
- " 4. " " 4 " " "

The patient, during the investigation, should be placed in a darkened room, at not less than 16 feet from a point of light, which may be a candle, or gas light turned down low. He should look at the light through No. 1, and, at the same time, move the screen quickly before his eye. If the length of the axis of the eye be normal, and the refraction hence emmetropic, the point of light will remain stationary; should the eye be ametropic the light will dance with each movement of the screen. With No. 2, the light will appear single to an emmetropic eye, multiplied to one ametropic. With No. 3, the light which enters the two perforations will appear to the observer, when placed near to his eye, to come from two large circles, at the screen, which overlap each other at their inner borders. In this overlapping space only will the test light appear double to an ametropic eye; and care must be exercised that the patient uses both apertures, and not one only; and that his attention is fixed upon the "overlapping space." This screen is provided with a piece of ruby glass, which can, at pleasure, be pushed over one perforation, and thus color the light which enters it red. Let it be supposed that a person with myopia is under examination, and that he sees the light point in the overlapping space as two lights. On pushing the red glass over the hole towards the right side, the light on the right appears crimson, and thus indicates that the axis of the eye is too long. Should the axis be too short, and hypermetropia be present, the left hand light would become colored, when the right hand hole was covered with red glass.

With No. 4, we are able to determine, without test glasses, the degrees of optical defects, by estimating the apparent distance apart of the two lights as they appear

Fig. 143.



Dr. Thomson's Optometer.

to an ametropic eye. There is a measured and fixed quantity, 4 millimetres, in the screen, and the patient should be placed at a fixed distance, 5 metres, from the light, when the degree of defect, and the convex or concave glass proper for its correction, can be ascertained by the measurement of the distance between the two lights. To render this of service clinically, these quantities have been reduced to the English measure, and a table has been made, as will be seen below, to indicate at a glance the optical defect, which accompanies each separation, in inches, of the two lights.

The patient being placed 16 feet from a small point of light, when it appears double, approach to it a second light, held in the surgeon's hand, until of the four points which the patient then perceives, the right hand one of the fixed, and the left hand one of the moving lights, are superimposed, and the patient sees but three; then ascertain with an ordinary measure the distance between the two lights, and its corresponding optical defect can be read off from the table.



Black Tin Disc.

A blackened tin disc, fig. 144, ten inches in diameter, having white lines one inch apart painted on its face, attached to a spring candlestick by a pivot, having in its centre an opening $\frac{1}{4}$ inch in diameter, through which the light of a candle may be transmitted, affords a very useful instrument. Let the patient regard this small point of light, and when he sees it double, he can at the same time determine the number of white lines between the lights, and hence the distance, since the lines are one inch apart. By rotating the disc and changing the position of the screen, any meridians of the eye can be examined, in cases of astigmatism.

By examining the table it will be observed that a separation of 1 inch indicates an ametropia of $\frac{1}{3}$, and may be corrected by a + or - $\frac{1}{3}$, which will fuse the two lights into one.

Distance of Lights Apart.		Degree of Ametropia.		Distance of Lights Apart.		Degree of Ametropia.
$\frac{1}{2}$ inch	=	$\frac{1}{8}$		5 inches	=	$\frac{1}{4.5}$
1 "	=	$\frac{1}{3}$		6 "	=	$\frac{1}{4}$
$1\frac{1}{2}$ "	=	$\frac{1}{2}$		7 "	=	$\frac{1}{3.5}$
2 "	=	$\frac{1}{2}$		8 "	=	$\frac{1}{4}$
3 "	=	$\frac{1}{2}$		9 "	=	$\frac{1}{4}$
4 "	=	$\frac{1}{2}$		10 "	=	$\frac{1}{4}$

The following diagram, fig. 145, of an emmetropic eye indicates the path of the light admitted through each opening, and the position of each image which is thus

Fig. 145.

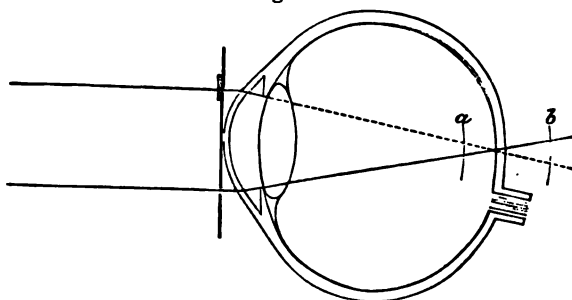


Diagram showing Hypermetropia at a, Myopia at b.

formed. When the eye is emmetropic, and the retina at its proper point, the two images are superimposed and appear as one. When the axis is too short, in hypermetropia, or too long in myopia, two pictures must be formed upon the retina, and perceived by the patient. The dotted line represents the path of the red ray, which falls upon one side of the retina in hypermetropia, and upon the other in myopia; a fact which enables these defects to be instantly distinguished.

When great accuracy is desired the power of accommodation should be paralyzed

by dropping a solution of atropia into the eye. A few experiments made by the surgeon upon his own eyes, aided by a few glasses, will give readiness in using this test upon patients. The only test object required is the point of light, and that convex or concave glass which fully unites the two lights into one, will give the highest visual power. The refraction may also be determined in cases of amblyopia, or in opacities of the media, when the visual power is so reduced as to render the use of any test letters impracticable.

FOREIGN BODIES IN THE EYE.

Foreign bodies are liable to pass into the eye, and to bury themselves in its structures, where they at once become a source of suffering and inflammation. They are of various kinds, as scales of iron, bits of glass, particles of stone and coal, shot, splinters of wood, and gun caps. Although every part of the organ may be thus injured, the cornea, from its exposed situation, is most frequently affected, the extraneous substance being either firmly imbedded in its lamellæ, lodged immediately beneath its epithelial investment, or forced into the anterior chamber, one end, perhaps, presenting externally. Great care is often necessary to discover its presence, especially when it is very minute, when it is composed of metal, or when it lies immediately in front of the pupil, the black background of which has a tendency to obscure it, so as to prevent it from being easily seen. The best way to examine the part is to stand behind the patient, as he sits upon a chair fronting the window, and then, the lids being raised, make him move the eye about in different directions, thus enabling the light to fall upon every point of its surface. In this manner no object, however minute, can possibly escape detection.

The removal of foreign bodies from the cornea requires more skill and tact than is generally imagined. I have repeatedly had patients sent to me from a great distance, because the attendants were unable to afford the necessary relief, and that, too, when the case was of the most simple nature. When the eye is much inflamed, when the substance is buried at a considerable depth, or when the patient is a child, or a very nervous, irritable, or excitable person, it will be well to exhibit chloroform before we proceed to the extraction, otherwise serious annoyance will arise. The upper lid being properly elevated, and the globe securely steadied by the finger, or, in the event of anæsthesia being employed, by toothed forceps, very much as in the operation for strabismus, a delicate cataract needle, or the point of a lancet, is insinuated around the foreign body, which is thus lifted out of its bed without any digging, a process which cannot be too carefully avoided, on account of its liability to be followed by severe inflammation and extensive opacity. A scale of iron that has been retained in the cornea for a few days is liable to become oxidized; hence, it may break under the instrument, and require to be extracted piecemeal. When the foreign body is firmly imbedded in the layers of the cornea, it is best to make an incision over it, to its full length, with a cataract knife, and then to dislodge it with a small needle. Should it have perforated the cornea in such a manner as to render it impossible to lay hold of it with the forceps, the puncture should be enlarged until this may be safely done, care being taken, if there is danger of the substance slipping back into the anterior chamber, to make counter pressure during the extraction by a delicate needle passed behind the cornea. All officious interference is, of course, avoided in these cases, especially rude and extensive probing, as it might prove worse than the retention of the extraneous substance.

Among the more unfortunate accidents of this kind met with in this country are lacerated wounds of the eye, made by fragments of gun caps, which often pass through the iris into the vitreous humor, and cause violent and destructive inflammation, attended by almost insupportable pain, lasting as long as the foreign body remains in the organ. I have seen more than a dozen of such cases, in every one of which the sight was completely annihilated, and the suffering was of the most violent character. If probing of the eye is ever justifiable, it is under such circumstances; and I am not certain whether the foreign substance should not be extracted at all hazard. By putting the patient under the influence of anæsthesia, the operation may be conducted with comparative safety, and with great probability of success.

I have seen several cases of bad injury of the eye inflicted by small shot; and in military practice it is not uncommon for the organ to be wounded by bullets, pieces

of iron, and splinters of wood. Destructive inflammation always follows the lodgment of such bodies, and the rule, therefore, is to get rid of them as speedily as possible.

The question may here be asked, what should be the treatment when a foreign substance, lodged in the interior of the eye, cannot be extracted? Where useful vision yet remains, and the foreign body is creating no irritation, the case should be kept under close observation, and the patient cautioned to seek aid upon the appearance of symptoms of irritation in the sound or uninjured eye. Where useful vision is destroyed, and the foreign body yet remains, giving rise to destructive inflammation, the eyeball should be extirpated to remove the cause of a probable sympathetic ophthalmia in the sound eye. Although dissection has shown that foreign bodies in the eye, as shot, pieces of iron, and gun caps, may become encysted, yet such an event is extremely rare, and does not afford immunity against future attacks of inflammation. As long, in fact, as the extraneous substance remains, it is liable at any time, whether free or adherent, to provoke suffering and disease, and to induce sympathetic inflammation in the sound eye.

Gunpowder is often imbedded in the coats of the eye, and I have seen cases where it penetrated the cornea and became fixed in the lens and iris. The worst accidents of this kind occur in mining and rock-blasting. Excessive pain and discomfort attend them, increased by the solution of the nitre in the tears, and followed by high inflammation. The treatment consists in picking out the grains of powder, without delay, lest the edges of the wound should close over them, and so oppose their removal.

Frightful injuries are liable to be inflicted upon this organ by hot fluids, as water, steam, pitch, sulphur, lead, solutions of soda and soap, and also by hot iron, hammered upon the anvil, the sparks flying off and forcibly striking the eye. The effects vary according to the temperature of the substance, and the duration and violence of the contact. In the milder forms there may merely be some discoloration, or discoloration and slight vesication, with more or less pain; in the more severe, on the contrary, the part touched is either killed outright, or the tissues are so much injured as to slough from the consequences of the resulting inflammation. The indication, in these cases, is to remove any foreign matter that may be present, and then to employ antiphlogistic measures, early and efficiently, in the hope of saving structure and function. Molten lead is apt to collect in the folds of the conjunctiva, where it should be sought for with great care, lest it may escape detection. Pitch, if firmly adherent to the eye, may be detached with olive oil; iron is best picked out with the point of the lancet.

Various chemical irritants, as the alkalies and acids, are capable of producing severe injury by their contact with the eye, causing violent pain, opacity of the cornea, and excessive inflammation, often terminating in sloughing and total blindness. The treatment of such accident is sufficiently obvious. The first indication is to wash away with the hand or syringe as much as possible of the extraneous matter by the free use of cool or tepid water; and the second to neutralize what remains by the application of some alkaline or acid lotion, according to the nature of the substance with which the mischief has been inflicted. If the eye has been touched by an acid, the most efficient remedy will be a weak solution of bicarbonate of potassa or soda; an alkali, on the contrary, is most effectually neutralized by an acid, as a wash of vinegar and water, aided, if necessary, by the vapor of hydrochloric acid. The eye, in either event, should be bathed for a long time after the extraneous substance has been dislodged, and then well anointed with olive oil, a full anodyne being used to allay pain, and leeches to moderate inflammation when necessary.

Nitrate of silver, too freely put upon the eye, whether accidentally or designedly, is readily neutralized by a weak solution of common salt.

Quicklime speedily destroys the structures of the eye, by inflicting a double injury by its chemical action and by the evolution of heat under the influence of the tears and mucus. The foreign matter having been picked away, the organ should be promptly syringed with a weak solution of vinegar and water, and then thoroughly coated with oil.

DISPLACEMENT OF THE BALL OF THE EYE.

Displacement of the globe of the eye, technically called *exophthalmos*, may be produced by various causes, of which the most common are different morbid growths in and around the orbit. A mass of fat, an *exostosis*, or cyst, by filling up the bottom of this cavity, may thrust the eye forwards, out of its natural position, and even force it out upon the cheek, completely beyond the lids. Similar effects are sometimes caused by polyps of the nose, by tumors of the maxillary sinns, and by morbid growths at the base of the brain. When the displacement is very great, so that the optic nerve is put much upon the stretch, as well as compressed, dimness of sight, if not total blindness, is apt to ensue. When the dislocation is the result of an accumulation of fat in the orbit, it may effect both organs simultaneously, as in the case of a black boy, twelve years old, who had a remarkable protrusion of both eyes ever since he was two years old. The balls hung, as it were, from their sockets, projecting nearly half an inch beyond the level of the nose. They preserved their natural direction, but could not be moved about, nor were they at all enlarged or hypertrophied. The sight was unimpaired. The upper lids were remarkably full towards the eyebrows, and were one inch and a half in the vertical direction, by two inches and a quarter in the transverse. Notwithstanding this inordinate development, they were insufficient to cover the ball of the eye completely. The lower lid was about the natural size. The right cornea had an opaque spot upon it, and the pupil was vertically elongated. The orbits did not contain any hard substance or tumor, as the finger could be pushed into them some distance between the brow and the upper part of the ball. The boy had occasionally had neuralgic pains in the eyes, with lachrymation, but in other respects he had been well. The protrusion had been for some time stationary when he died of gastritis. Upon removing the contents of the orbits, the cause of the protrusion proved to be an accumulation of fat behind each ball, within the muscles, upon which the organ rested, as in a cup. The optic nerves were normal, but somewhat longer than usual. The lachrymal glands, forced considerably forward, were of the natural size, color, and structure. The inner wall of the orbit, especially the left, was more prominent than usual, but had no agency in the production of the protrusion. Both eyes were perfectly sound.

An abscess, seated deeply within the orbit, may occasion serious displacement of the eye, as in a case related by Professor Arlt, of Vienna, occurring in a child only fifteen days old. The protrusion of the ball was accompanied by great *œdema* of the lids, and was promptly relieved by the evacuation of a teaspoonful of thick pus.

There is great prominence of the eyeballs in the affection known as Graves' Disease, or *exophthalmic goitre*, which is observed most frequently in females, and is marked by a too frequent and tumultuous action of the heart, along with an enlargement of the thyroid gland. Vision is not impaired, and no lesions are to be observed with the ophthalmoscope beyond an engorged condition, with pulsation, of the retinal veins. The pathology of the disease is obscure, but it is believed to be one of the nervous system. Iodine, with iodide of potassium, may be given in combination with tonics.

The eye is occasionally dislocated from its socket by external violence. I have never met with such a case in the human subject, but once saw a little poodle, which, in a fight with a large mastiff, half an hour previously, had the misfortune to suffer from this accident. The eye hung completely out upon the cheek merely by the optic nerve, without any injury to the ball, but with great stretching of the different muscles, two of which were torn nearly entirely across. The displacement had evidently been produced by the canine tooth of the mastiff. The eye was restored without any difficulty, and the animal made a rapid recovery, without the slightest apparent impairment of vision.

When the displacement is caused by a morbid growth, the latter may be removed in such a manner as to avoid injury to the eyeball or any of the accessory structures.

DISEASES OF THE CONJUNCTIVA.

Inflammation.—The conjunctiva is the seat of various forms of inflammation, known by the generic term *ophthalmia*, as the catarrhal, traumatic, pustular, purulent, gonorrhœal, and granular.

1. *Simple Inflammation.*—The most simple form of conjunctivitis is that which results from the suppression of the cutaneous perspiration, exposure of the eye to intense light, the lodgment of a foreign body, disorder of the digestive apparatus, or, in short, from any slight and transient cause, whether acting directly upon the

Fig. 146.



Simple Conjunctivitis.

eye itself, or indirectly through the general system. The symptoms are abnormal redness of the conjunctiva, pain, lachrymation, and intolerance of light, with a slight discharge of mucus, barely sufficient, perhaps, to glue the lids gently together in the morning. The vessels, as seen in fig. 146, are small, tortuous, and few in number. There is no tumefaction of the lids, no involvement of the cornea, iris, or sclerotica, and no purulent secretion; in a word, the inflammation is of the most simple character, and, unless neglected or badly managed, generally disappears in from two to three days, the eye rapidly regaining its natural characters and functions.

An inflammation like this, however, may, if mismanaged or neglected, become a most serious affair, and be productive of extensive structural mischief. The discoloration will then be more diffused, the conjunctiva exhibiting a uniform scarlet or bloodshot appearance; there will be excessive lachrymation, great increase of pain, severe intolerance of light, a muco-purulent discharge, more or less profuse and glutinous, and involvement of some of the other structures of the eye.

The redness of conjunctivitis is peculiar, not only in the milder and more common forms of the disease, but in every other. It is of a scarlet hue, and may occur either in circumscribed spots, or, as is more generally the case, be diffused over the whole anterior surface of the ball, except the cornea, according to the extent of the inflammation; very generally it affects also the inner surface of the lids, and it may even be greater there than elsewhere. It is seated exclusively in the conjunctiva and ocular fascia, or in the conjunctiva and the connective cellular tissue, and is usually most conspicuous where the membrane is reflected from the lids over the sclerotica. The arrangement of the vessels is also peculiar. They are spread out arborescently, and are perfectly movable, tortuous, and remarkably distinct, hundreds being visible in every direction, where in the natural state there is hardly one. As the disease augments in intensity, the vessels are, as it were, lost, the inflamed surface exhibiting a uniform scarlet appearance.

There is a marked difference between the redness of conjunctivitis and that of scleritis. In the former, the color of the inflamed surface is scarlet, especially if the disease have made considerable progress; in the latter, on the contrary, it is pink or lilac, the reddish hue contrasting beautifully with the naturally bluish tint of the fibrous structure; in the one it is superficial and movable, in the other deep and fixed. In conjunctivitis the vessels are large and ramiform, anastomosing with each other in every conceivable direction; in scleritis they are very small, and disposed longitudinally, running from behind forwards in parallel lines towards the cornea, where they form a distinct zone, often extending completely around the eye.

The pain in conjunctivitis is seldom severe, except in the more violent forms, when it is often exquisite. In general, there is merely a sense of uneasiness, or a feeling as if there were a particle of foreign substance in the eye. The uneasiness, pain, or aching is steady, but liable to vesperal exacerbations and remissions, and confined mainly to the site of the disease. In scleritis, it is severe, deep-seated, paroxysmal, and circumorbital, generally affecting the temple, cheek, and forehead.

The lachrymation is often considerable, even in the milder forms of conjunctivitis; the tears are hot and scalding, and perhaps gush out in a full stream the moment the lids are separated. The flow may continue profusely for an indefinite period, but in general it lasts only a few days, when it sensibly diminishes, and soon after entirely disappears, especially if there be much muco-purulent secretion.

The intolerance of light varies; sometimes it is very insignificant, at other times excessive. In general, however, it is an important symptom, for there is hardly a case of ophthalmia where there is not more or less of it. In the strumous variety it is characteristic, and is often so intense as to induce the sufferer to bury his face in the bedclothes, or, if he is a child, in his nurse's lap.

Much difference also obtains in regard to the discharge of mucus, pus, or muco-purulent matter. In the more simple cases, there is usually only a slight increase of the natural secretion; but, if the disease is at all severe, the discharge will be abundant, thick, glutinous, and decidedly muco-purulent. Indeed, there are certain varieties of ophthalmia which derive their distinctive features from the character of the secretion of the inflamed surface; as, for example, in purulent and gonorrhœal conjunctivitis. The Meibomian glands, participating in the inflammation, also furnish an abundant secretion, of a peculiarly viscid nature, which, mingling with that derived from the mucous membrane, causes the agglutination of the edges of the lids, so common and so annoying in the more severe forms of conjunctivitis. In scleritis and corneitis, the discharge of mucus is generally trifling, while the formation of pus is a comparatively rare occurrence.

Tumefaction of the conjunctiva is present only in some cases, and is dependent, not upon any marked distension of the membrane itself, but upon the infiltration of the subjacent cellular tissue, commonly known at the present day as the ocular fascia, which plays so important a part in all the more violent forms of conjunctivitis. Possessed of great laxity, this texture admits of extraordinary distension with serum, or sero-plastic matter, giving rise to what is called *chemosis*, fig. 147, a cause of such frequent sloughing of the cornea. When the tumefaction exists in its worst degree, it forms a kind of rim around the cornea, often several lines in depth, causing the front of the ball to have a cup-shaped appearance. Much swelling is also frequently present at the inner canthus, and at the point of reflection of the conjunctiva from the lids over the sclerotica. It is worthy of note that this symptom is entirely absent in scleritis and corneitis, as well as in the more deep-seated inflammations of the eye.

Swelling of the lids is rarely present in simple conjunctivitis, or even in many of the more severe cases, whilst, in purulent and gonorrhœal ophthalmia, it is a conspicuous and troublesome occurrence, greatly increasing the local suffering, as well as materially interfering with the examination and medication of the eye. In this respect, again, conjunctivitis differs characteristically from scleritis and corneitis, in which the lids are either not swollen at all, or only in a very slight degree.

2. *Diphtheritic Inflammation*.—Under this appellation, Von Graefe originally described a form of external ophthalmia, the characteristic feature of which is a deposit of lymph in the subconjunctival cellular tissue both of the ball and of the lids. The affection, which may be either sporadic or epidemic, is most common in children under three years of age, is sometimes, if, indeed, not generally, contagious, and is often associated with diphtheritic inflammation in other parts of the body. Both eyes are usually involved, and the exudation is situated in the cellular layer beneath the conjunctiva, which is always considerably elevated above the cornea, the latter lying, as it were, in a hollow, while the lids are greatly thickened, stiff, inelastic, and immovable. Sometimes, but rarely, lymph is also found upon the surface of the conjunctiva. The tumid part is smooth, and of a pale yellowish, cineritious, or reddish-white hue, and remarkably firm in its consistence. The circulation is greatly embarrassed, the superficial vessels are enlarged, and numerous apoplectic specks denote mechanical obstruction and rupture. In the more advanced stages of the disease, few vessels are visible; they exhibit the appearance rather of broken canals than of ordinary vascular tubes, and, if the part be incised, neither blood nor lymph escapes from the indurated structures.

The symptoms are usually very distressing. Photophobia is present in greater or less degree. The heat is very intense, as is shown both by the touch, and by the rapid evaporation of fluid applications. The pain is very great, even at the begin-

Fig. 147.



Chemosis, or Swelling of the Conjunctiva.

ning, and the conjunctiva is so sensitive as to be intolerant of the slightest manipulation. Considerable lachrymation commonly exists, and the accompanying discharge, seldom copious, is of a yellowish or dirty grayish color. Gradually, as the action progresses, the cornea becomes opaque, ulcerated, and finally, if relief be not afforded, gangrenous, from the strangulation of its vessels. Large portions of the ocular conjunctiva are sometimes involved in the slough. The patient is feverish and restless; the disease rapid and grave. In the worst forms of the affection, the sight and even the eye itself may be destroyed in twenty-four hours from the time of its first appearance.

3. *Purulent Inflammation*.—Purulent ophthalmia derives its characteristic features from the nature of the attendant discharge, which is generally profuse, thick, viscid, and irritating; it sets in within a few hours after the attack, and continues steadily until the disease disappears. The affection is particularly prevalent in the warmer latitudes, where it is often epidemic, although sporadic cases are constantly met with everywhere. It is most common among the humbler classes, and seems to be caused by atmospheric vicissitudes; but, as the matter which is so profusely secreted is contagious, the disease is communicated by actual contact or inoculation. The inflammation is exceedingly vehement, and is accompanied by the most atrocious pain,

Fig. 148.



Acute Purulent Ophthalmia.

swelling, discharge, and intolerance of light; the lids, as seen in fig. 148, are enormously distended; the conjunctiva is profoundly chemosed; and the cornea, buried almost out of sight, becomes speedily opaque, and finally sloughs, vision being irretrievably destroyed. Of the frightful character of this distemper, when it prevails as an epidemic, some conception may be formed when it is stated that the Chelsea and Kilmainham hospitals contained at one time, soon after the return of the British troops from Egypt, 2317 soldiers who were totally blind from its effects. The case of the ship *Rodeur*, a French slaver, affords a good illustration of the manner in which the disease spreads under circumstances favorable to its propagation. Of the blacks, 160 in number, among whom it first broke out fifteen days after their departure from the coast of Africa, 39 of those who survived were totally blind, 12 lost each an eye, and 14 had corneal opacity. Of the crew, consisting of 25 persons, only one escaped, and he was attacked soon after he landed at Gaudaloupe. It is asserted that 30,000 cases of this disease occurred in the Prussian army, from 1813 to 1821; and that in 1862, 4798 men were disabled by it at one time. The Belgian army, it would seem, has suffered still more extensively.

Purulent ophthalmia occasionally occurs in the *infant* within a few days after birth, in consequence, as has frequently been stated, of inoculation with gonorrhœal or leucorrhœal matter derived from the mother at that time. That such an occurrence is

Fig. 149.



Purulent Ophthalmia in the Newly-born Infant.

possible is unquestionable, for multiplied observation has fully established the fact; but that it is generally or even frequently the cause of the disease is certainly improbable, since, of the numerous cases that I have seen of it, I have never been able to trace a solitary one to the effects of inoculation of any kind, notwithstanding the most minute and circumstantial inquiry into its history. My conviction is, that the disease, as it usually appears, is of atmospheric origin, depending upon the same causes as the purulent ophthalmia of adults, and that it is, therefore, wholly free from specific poison, although, perhaps, capable of being communicated by inoculation. However this may be, it is characterized by an abundant discharge of a thick, yellowish pus, great redness of the conjunctiva, and so much swelling of the lids as to render it extremely difficult, if not impossible, to separate them, so as to get a fair view of the cornea, which is often early involved in the disease. These appearances are well seen in fig. 149. The most healthy children, as well as the most puny, are subject to this disease, the former, according to my experience, suffering more frequently than the latter; it generally runs a rapid course, and, unless properly managed, often eventuates in total blindness, especially when, as usually happens, both eyes are affected.

4. *Gonorrhæal Ophthalmia*.—This disease is produced by the contact of gonorrhæal matter. It is a most virulent form of inflammation, spreading with great rapidity from the conjunctiva to the other structures of the eye, which is usually completely destroyed in a few days. Its principal phenomena are excessive discoloration, and swelling of the conjunctiva and of the lids, profuse muco-purulent discharge, of a yellowish and very viscid character, great pain, lachrymation, intolerance of light, and early opacity of the cornea, which soon dies and sloughs, thus permitting the escape of the humors with the consequent collapse of the eye, as in fig. 150. Positive inoculation is necessary to the production of this disease; I have never seen an instance where it showed itself as a secondary affection, and I question the possibility of such an occurrence, notwithstanding the many apparent proofs that have been adduced in its support. The disease usually begins in one eye, but in most cases the other becomes also involved from the accidental contact of the matter.

There is something very curious about this disease, which has not yet been satisfactorily elucidated. If gonorrhæal ophthalmia is really an entity, why is it that it does not occur more frequently, for there are thousands of persons, ignorant and filthy, who, while laboring under specific urethritis, carry their fingers, besmeared with matter, to the eye, often rubbing and scratching it, and yet do not contract the disease? May we infer from this that it is difficult of propagation, or that it can only be produced in this way in some individuals, and not in others? Authors constantly adduce cases in which this variety of ophthalmia is said to have been induced by the contact of the patient's urine, employed for bathing the eye, under the popular belief that it is a good and speedy cure for the disease. Now, is this possible? Does not this admixture of the two fluids effectually destroy the specific poison of gonorrhœa? Could the matter of smallpox, chancre, and other diseases withstand the neutralizing influence of so acrid and readily-decomposed a fluid as the urine? These questions afford food for reflection, and should, if possible, be settled before we receive as true all that has been written upon the subject. This is the more necessary, because it is well known that the ordinary, non-specific form of purulent ophthalmia often destroys the eye completely in less than three days after its outbreak. Meantime, the only evidence that the disease is of a gonorrhæal nature is derived from its history; that is, we cannot be certain that the affection of the eye is specific, unless we know that the patient is laboring under specific urethritis. Such a diagnosis is, to say the least, not very philosophical, for it may well be asked whether it is not possible for a non-specific but destructive inflammation of the eye to take place during the progress of

Fig. 150.



State of the Lids in Gonorrhæal Ophthalmia.

an ordinary gonorrhœa, and yet be entirely independent of it? As for myself, I can readily conceive of such an occurrence, although, granting all that might be said respecting it, it would be very natural to view the two affections in the light of cause and effect.

5. *Granular Inflammation.*—The lids are occasionally the seat of a villous condition of the conjunctiva, liable to degenerate into little bodies, which, from their

Fig. 151.



Granular Lid.

resemblance to the structures observed upon a healing ulcer, are denominated granulations, and which are well seen in fig. 151. These bodies, which are nothing but enlarged villi, found in such abundance upon nearly all mucous surfaces, are never present in ordinary conjunctivitis, while they are exceedingly common in certain varieties of that disease, especially such as are attended with purulent discharge, often forming in an almost incredibly short time. They are always most abundant upon the upper lid, where they are frequently extremely large and numerous, giving the mucous surface a rough, mammillated appearance, not unlike that of a strawberry; they are of a deep red color, and usually occur in groups, which are often separated by well-marked fissures. Similar bodies are generally met with on the lachrymal caruncle, although seldom in large numbers. On the lower lid they are always comparatively small, and more straggling than on the upper.

In the Southwest, where these granulations are extremely common, I often saw them form in immense numbers, and of extraordinary size, in less than forty-eight hours from the commencement of the disease. In some regions of that country, especially in the Wabash Valley of Indiana, and some parts of Illinois, Kentucky, and Mississippi, the disease is occasionally epidemic. Boatmen on the Ohio, Mississippi, and other rivers are remarkably liable to its attacks. During my residence at Louisville, I treated large numbers of cases of this kind, and the cities of St. Louis, Memphis, New Orleans, and Chicago have always had a full share of them. The malady was much more common in men than in women, and in young and middle-aged subjects than in children and old persons, and it appeared to me to be often of a miasmatic origin. However this may be, it is certainly most frequent in those regions of the Southwest where neuralgia and intermittent fever are most prevalent. Persons who sleep out in the open air, or who travel much at night, are particularly liable to its attacks.

The disease is always attended with a profuse discharge of thick, viscid, yellowish pus, and with the other phenomena of the more violent forms of conjunctivitis. From the friction which the granulations exert upon the ball, the cornea is soon involved, and is often rendered completely unfit for the purposes of vision. As this peculiar state of the lids can only be ascertained by a careful examination of their inner surface, they should always be thoroughly everted whenever there is the slightest purulent discharge. A great number of cases have come under my observation where, from neglect of this precaution, total blindness was produced.

Trachoma, or vesicular granulation, is another form of the disease, characterized by the appearance in the conjunctiva of round, white vesicles, looking like grains of boiled sago; this is epidemic, and transmitted by contagion.

Treatment.—The milder forms of conjunctivitis generally yield to very simple treatment. Confinement in a dark room for a few days, light diet, an active purge, and tepid, cool, or cold bathing of the eye, with, perhaps, a Dover's powder at bedtime, constitute the most appropriate remedies. When the inflammation is more violent, or disposed to be somewhat obstinate, the list may be increased by the addition of the antimonial and saline mixture, with greater restriction of the diet, and the abstraction of blood from the neighborhood of the affected tissues by leeching or cupping. Depletion by the lancet can be required only when the patient is plethoric and the inflammation intense. One good, thorough bleeding, at the commencement of the disease, while the patient is in the semierect posture, may cut short an attack, which might otherwise eventuate in the destruction of the eye, or in great suffering, with more or less impairment of sight.

Among the important remedies in the different forms of conjunctivitis cathartics hold a prominent rank; unless there is some positive contra-indication, they should partake somewhat of a drastic character, so that they may produce both a derivative and purgative effect. They should be given early and late in the disease, with proper regard, of course, to the strength of the patient and the state of the intestinal mucous membrane. Among the more appropriate articles are senna and Epsom salt, jalap and cream of tartar, and the compound calomel pill. When decided evidence of gastric disorder exists, the use of the purgative may be preceded by the exhibition of an emetic. Vomiting, however, is only admissible so long as there is no tendency to disorganization of the eye; for, when this is present, the concussion which it would cause could hardly fail to prove injurious. Mercury is rarely given in conjunctivitis, whatever may be its degree or character, experience having shown that it is destitute of any controlling power. Anodynes must be administered freely, whenever there is much local suffering, or inability to sleep, in every stage of the malady, unless there are strong and decided contra-indications; for, besides answering these important purposes, they usually prove of immense benefit in affording quietude to the affected organ, an object of such great consequence in the treatment of inflammation generally. Elevation of the head and exclusion of the light will, of course, receive due attention.

Locally, none but the mildest remedies should be employed. It is a great mistake, yet one which is constantly committed, to use strong applications to the eye in every form and stage of the inflammation. Often have I seen a simple conjunctivitis, which in a few days might have disappeared spontaneously, converted into a violent, obstinate, and protracted disease by the untimely use of an improper collyrium! If a collyrium be admissible at all, it is only, as a general rule, after the morbid action has been, in some degree, subjugated by other means, when it has assumed a subacute character, or become chronic. When the symptoms are urgent and threatening, I sometimes depart from this rule, but even then seldom without regret. In the purulent and gonorrhœal varieties of the affection, many ophthalmic surgeons urge the employment of strong collyria, at an early stage of the attack, on the ground of their beneficial influence in controlling inflammation. I have used them myself in such cases, but seldom without a conviction of their injurious effects.

The most valuable articles of this class of remedies are the different preparations of lead and zinc, wine of opium, and nitrate of silver, the latter of which is at once the most potent and the most abused. The lead or zinc may each be used in the form of solution, in the proportion of one, two, or three grains of the salt to the ounce of distilled water, a few drops being poured upon the inflamed surface twice or thrice in the twenty-four hours. If the application smart beyond a few minutes, it must be weakened, or employed less frequently. The best preparation of opium is Sydenham's laudanum—the wine of opium of the shops—diluted with three or four parts of water, or dropped upon the eye in a pure state. The strength of the nitrate of silver should vary from the eighth of a grain to two grains for ordinary cases, while in the more violent it may range from five to sixty. When the solution is very strong it should be applied by means of a camel-hair pencil, the inflamed surface having previously been dried with a soft linen rag. When the lids also suffer, the best plan is to touch them and not the ball, their return to their natural position serving to diffuse the caustic over the whole of the diseased structure. Whatever collyrium be used, its effects must be carefully watched, and whenever they are found to flag, another must take its place. Solid nitrate of silver ought seldom to be used about the eye.

In the more severe cases of conjunctivitis, the patient will derive great comfort from poppy fomentations, cloths wrung out of warm water and opium, and the application of medicated steam, directed upon the eye by means of an inverted funnel. Sometimes a light poultice is very soothing, especially when the surface is wet with laudanum, or laudanum and acetate of lead.

The treatment of *diphtheritic* ophthalmia must be prompt and decisive. The constitutional remedies must be employed with vigor; the patient must be confined in a dark room, and blood may be taken either from the arm, or by leeches from the forehead, cheeks, lids, or temples. The most reliable topical means are early and free scarifications of the swollen conjunctiva, followed by the thorough application of the solid nitrate of silver, repeated, in the more severe forms of the disease, at least twice in the twenty-four hours, the surface being washed immediately after

with a solution of common salt. The incisions should extend down to the surface of the sclerótica, otherwise it will be almost impossible to prevent opacity and sloughing of the cornea. When the lids are very stiff, glossy, and tumid, from serous and plastic deposits, great benefit will accrue from external punctures and incisions, and, also, in many cases, from the use of blisters and tincture of iodine.

In *purulent*, gonorrhœal, and other forms of ophthalmia, attended with unusual swelling and a rapid extension of the morbid action, the most appropriate measures are, free incisions of the inner surface of the lids, extensive scarification of the chemosed conjunctiva, and the injection of the eye, every half hour, with a solution of opium and bichloride of mercury, in the proportion of two grains of the former and one-eighth of a grain of the latter to the ounce of tepid water. If the discharge of pus is very profuse, the inner surface of the lids may be pencilled over twice a day with a strong solution of nitrate of silver. The bichloride of mercury is a remedy of great potency in all cases attended with copious puriform deposit. The use of the syringe I regard as indispensable, as it is the only means by which we can remove the irritating matter, and effectually medicate the inflamed surfaces.

In the *purulent ophthalmia of infancy*, I have usually effected excellent and even rapid cures by the injection every few hours of tepid water, or milk and water, followed immediately after by a solution of bichloride of mercury, from the eighth to the twelfth of a grain to the ounce of water, and the constant application of a light elm poultice. Internally, we may give, every eight hours, a minute quantity of Dover's powder, and calomel, to act upon the skin, and to allay pain. The bichloride of mercury is, of all the local means that I have ever tried in this affection, the most efficacious in arresting discharge. Very weak solutions of lead, zinc, and alum are also beneficial, but altogether inferior to the bichloride. When the eye is unusually irritable and sensitive to light, the addition of a small quantity of belladonna to the collyrium will commonly be highly advantageous. One of the great points in the treatment of this and other forms of *purulent ophthalmia*, is to get rid of the acrid secretions, which, if allowed to remain, always act as local irritants. As to leeches and counter-irritation, I rarely employ them.

If the child is feeble, a minute quantity of quinine is given three or four times a day, and care is taken that a sufficiency of good nourishment from the mother is obtained. As the disease improves, exercise in the open air is enjoined.

It is often very difficult to obtain a satisfactory view of the condition of the eye in this disease, owing to the excessive tumefaction of the lids. The proper way to accomplish the object is to place the child's head between the knees, and to draw the lids gently apart with the index fingers, avoiding any attempt at eversion, which, in such a condition, is quite impossible. The eye should always be well syringed before the examination, to prevent the matter from obscuring the ball.

The first thing in the treatment of *granular conjunctivitis* that should claim our attention is the state of the general health, often seriously deranged, in consequence of the joint agency of disease, confinement and ill-treatment. Purgatives are generally indicated, and often afford much relief; the diet must be carefully regulated; and, if there is much pain, interfering with sleep, a full anodyne must be administered at night, either by itself, with a diaphoretic, or a drachm of the wine of colchicum, the latter being particularly serviceable when the pain is of a rheumatic character. If the patient is plethoric, the antimonial and saline mixture must be given three or four times a day, along with a small quantity of morphia in each dose.

If the granulations are very large and exuberant, they should be shaved off with a sharp scalpel close down to the conjunctiva, without including this membrane in the operation; and, having encouraged the flow of blood with a sponge and tepid water, the raw surface should be cauterized with a stick of sulphate of copper, expressly prepared for the purpose. The part, being again exposed to a stream of water, to remove the redundant salt, is permitted to resume its natural position; the patient is directed to bathe the eye frequently for the next two days, and to anoint the edges of the lids at night with a little thick cream or fresh lard. If the granulations are comparatively insignificant, the use of the knife is dispensed with, and recourse is had to the copper, which should be repeated every third or fourth day. The copper should never be applied directly to the ball or lower lid, as that on the upper lid soon diffuses itself over the whole of the inflamed surface. In the intervals of the cauterization, the eye may be bathed, more or less frequently, with cool, tepid,

or cold water, simple, mucilaginous, or slightly astringent, as may be most agreeable to the part and system, or favorable to the reduction of the morbid action.

Instead of the copper, I sometimes use a strong solution of nitrate of silver, twenty, thirty, or even sixty grains to the ounce of water, applied very carefully by means of a camel-hair pencil to the inner surface of the upper lid, previously everted and dried. The two remedies may occasionally be advantageously alternated. Pencilling the granular surface with Goulard's extract is now and then followed by speedy amendment; but, on the whole, it is inferior to the copper and nitrate of silver. The great objection to the ordinary solutions of lead is their liability to incrust the cornea, and thus produce opacities.

When the reproductive tendency of the granulations is very great, I have found marked benefit from frequent scarification of the lid, and the occasional application of two or three leeches to the neighborhood of the outer canthus. I know that the former of these remedies has met with much opposition, but I can attest its beneficial effects from ample experience.

A tonic course of treatment will generally be required with a majority of the patients in our larger cities, and in the wards of hospitals, and signal benefit will accrue from the use of quinine, iron, extract of bark, cod-liver oil, and similar articles, with a nutritious diet, exercise in the open air, and attention to the skin. Whatever means be adopted, steady perseverance, both on the part of the patient and the surgeon, will be indispensable to a final and permanent cure, for there is no disease more liable to relapse than granular conjunctivitis, or to cause serious complications, such as trichiasis, entropion, or pannus.

The corneal opacity, so common an attendant upon this disease, unless very great, usually disappears, as the lids regain their normal condition. Should it linger, daily applications to the edge of the lower lid of a little very dilute ointment of the nitrate of silver or red oxide of mercury may be made.

Finally, in the treatment of conjunctival ophthalmia, every case attended with muco-purulent discharge should be isolated, so far as the use of the bed, towel, and basin is concerned; for, although every discharge of the kind is not contagious, yet too much circumspection cannot be observed in regard to those whose occupation compels them to be constantly in contact with the subjects of these maladies.

Pterygium.—Pterygium is a hypertrophy of the conjunctiva, generally vascular, several shades darker than the surrounding surface, and of a triangular shape, the apex corresponding to the cornea, and the base to the inner canthus, as shown in fig. 152. It is commonly situated upon the nasal aspect of the eye, but it may occur upon the temporal side, or even in the perpendicular diameter of the organ. Only one such growth is ordinarily met with; in some cases two are observed, as in fig. 153, and instances have been recorded of three, and even four, although they are

Fig. 152.



Pterygium.

Fig. 153.



Double Pterygium.

extremely rare. Sometimes, also, the pterygium, instead of being horizontal or perpendicular, is oblique, and deviates from the triangular form.

The starting-point of a pterygium is generally at a short distance from the cornea, and presents itself as a little elevation, of a vascular, yellowish appearance, which, gradually assuming a membranous form, extends outwardly towards the canthus of the eye, and inwardly towards the cornea, upon which it always en-

croaches to a greater or less extent, rarely, however, passing beyond the middle line. When it is developed upon the nasal side of the eye, it generally, in its progress, involves the semilunar valve, and hence it has sometimes been supposed, although erroneously, to originate in that structure. The causes of pterygium are generally such as produce chronic inflammation, but in many of the cases that have fallen under my observation it came on spontaneously, without any antecedent or accompanying disease of this kind.

Pterygia vary much in their structure; some are quite thin, as if they consisted merely of an additional layer of conjunctiva; others, on the contrary, are very thick, and of a tough, fibrous consistence. Numerous vessels, generally arranged in a straggling manner, and occasionally granules of fat exist in them; but, in cases of long standing, they are often very white, and not vascular. That they consist mainly in a hypertrophic condition of the conjunctiva is shown by the fact that the morbid growth is inseparably incorporated with that membrane, that it always lies loosely upon the sclerotica, and that it follows the conjunctiva in its reflection over the cornea, where its attachment is always extremely close and firm.

The principal inconvenience of a pterygium is from its mechanical interference with the movements of the eye. It seldom produces pain, but the subjects of it are more prone to inflammation, and vision is materially impaired, when the membrane encroaches considerably upon the cornea.

Local applications are of no service, even in its earlier stages, nor would interference be advisable so long as the eye is comparatively comfortable, and vision not impaired.

Should an operation be demanded, it is easily executed by seizing the pterygium at its middle with a pair of forceps, drawing it away from the globe, and shaving it off with a narrow scalpel. Some surgeons prefer the scissors, but I am satisfied that the operation can be performed much more effectually, though perhaps not so rapidly, with the knife. When strangulation is preferred, it may be effectually

employed by transfixing the growth at the points designated in fig. 154, with two needles, armed with a single thread. When the needles are separated from the thread by scissors, four ends will be found below and two above the growth. Strangulation vertically is effected by tying the upper and lower threads, at the apex and base; and horizontally by tightening the upper loop, and tying the two threads which remain below.

Xeroma.—The word *xeroma* is employed to denote a remarkable dryness of the conjunctiva, chronic in its character, and associated with more or less thickening and induration of the membrane. The best idea that I can give of the diseased structure is that it resembles the eyelid of the land frog. The morbid change is universal, affecting the entire conjunctiva, although it is commonly most distinctly marked in the ocular portion. In two of the three cases that have fallen under my observation, it was also very conspicuous in the epithelial lining

of the cornea, which was singularly dry, slightly opaque, and studded with little grayish points, not larger than a clover seed. Of the origin and nature of *xeroma* we have no definite information, although it has generally been ascribed to the effects of inflammation. Again, it has been supposed to be caused by deficient lachrymal secretion; but such a state has been assumed rather than established by direct observation, and in a number of the reported cases of the disease it has been most satisfactorily demonstrated that the functions of the lachrymal gland were not materially, if at all, impaired. Nor can the affection be justly ascribed to a want of the proper secretion of the conjunctiva, seeing that the suppression of this secretion is a consequence, and not a cause, of the morbid change. *Xeroma* is usually confined to one eye, the sight of which is necessarily more or less diminished, if

Fig. 154.



Operation for Pterygium.

not wholly destroyed. In three cases, which I have had occasion to observe, it occurred in old subjects, had been in progress for many years, was attended with nearly total blindness, and came on without any assignable cause. A stiff, dry feeling of the eye, with some impediment of motion, was the chief inconvenience under which the patients labored.

Xeroma is an incurable affection. Temporary improvement sometimes follows the use of mildly stimulating unguents; but, beyond this, nothing is to be expected from local applications. In cases of recent standing, it might be justifiable to try the effects of excision of the diseased membrane, removing it in large sections at three or four sittings, at intervals of so many weeks. Such a procedure might, unless the reproductive tendency is very great, be perfectly successful.

Encanthis.—The lachrymal caruncle and the fold of the conjunctiva, called the semilunar valve, are liable to hypertrophy, known under the name of *encanthis*, represented in fig. 155. The enlargement, which occasionally attains a considerable bulk, extends along the inner margin of the lids, impedes the movements of the eye, and keeps up more or less irritation, with discharge. The tumor is often connected with obstruction of the lachrymal passages, and generally has an angry, reddish appearance. The proper remedies are leeching, scarification, and the application of nitrate of silver, with attention to the general health, which is frequently involved in the causation of the disease.

Fig. 155.



Encanthis.

A malignant tumor, of a mixed scirrhus and encephaloid character, sometimes springs from these structures; it is of a livid or purple hue, rough, knotty, or tuberculated on the surface, hard to the touch, and rapid in its growth, often attaining a considerable bulk in a few months. Its tendency is to progress, ulcerate, and finally to destroy life. Early and thorough excision affords the only chance of relief, which, however, is always very uncertain.

Diseases of the Submucous Cellular Tissue.—The only affections of the subconjunctival cellular tissue requiring notice, are, hemorrhagic effusions, œdema, fatty deposits, and the little parasite, called the cellular cysticerce.

Blood may be effused into the subconjunctival cellular tissue by any accident, as a blow, or spontaneously, without any apparent cause. Of the latter variety I have seen a number of instances, chiefly in young persons, who were otherwise in the most perfect health. The occurrence is unattended with pain, and the extravasated blood is either limited to one or two small points, or extensively diffused over the anterior part of the eyeball. The resulting redness is altogether different from that of inflammation. Very little is necessary in the way of treatment; indeed, the fluid usually rapidly disappears of its own accord, but its removal may be promoted by the use of astringent or stimulating lotions.

Edema of the areolar tissue beneath the conjunctiva is of two kinds, the passive and active. The first is the result of a slow effusion of serum, in consequence usually of a retarded state of the venous circulation, of which the exciting cause is compression by some tumor, abscess, or other obstruction; the conjunctiva is elevated, of a white, almost shining appearance, soft, inelastic, and perfectly free from pain. The active variety, usually known under the name of chemosis, is a much more serious disease; it has already been described in connection with purulent ophthalmia, with which it so often coexists, and of which it forms one of the most dangerous complications, from its tendency to induce gangrene of the cornea. It is always produced by inflammation, and is commonly of a sero-fibrinous character, and not purely serous as in the passive form. When it exists in a high grade, the swelling forms a ring around the cornea, often a few lines deep, by which this membrane is sometimes nearly buried. The proper remedy, as before remarked, is free scarification, to afford vent to the effused fluids, followed by the application of a weak solution of nitrate of silver. Nothing short of this will be likely to save the cornea.

A little *fatty tumor* occasionally forms beneath the conjunctiva, from the size of a currant to that of a pea, irregularly rounded, movable, and of a pale yellowish color. It generally receives a few straggling vessels, grows slowly, and is surrounded by a thin layer of condensed cellular tissue. Dermoid tumors, generally congenital, com-

posed of fibrous tissue, with fat cells, and containing a few hairs, are found upon the conjunctiva. The proper remedy for both is excision.

Melanosis may occur as a deposit near the edge of the cornea, or as a small pendulous growth from the conjunctiva, as large as a pea, which has a tendency to return after removal.

A species of hydatid, the *cellular cysticerce*, has been met with in this situation; the containing vesicle is about the size of a pea, and looks like a little bladder filled with water. Under the microscope, the parasite is seen to have its mouth encircled by distinct hooklets. It is sometimes developed at a very early age. The only remedy is extirpation.

DISEASES AND INJURIES OF THE CORNEA.

The most common affections of the cornea are wounds, inflammation, abscess, gangrene, ulceration, opacity, change of form, technically termed staphyloma, and fatty degeneration. Foreign bodies are also liable to enter it.

1. *Wounds*.—Wounds of the cornea may be the result of accident or design, and are either incised, punctured, lacerated, or gunshot, according to the kind of weapon with which they are inflicted. Incised wounds are generally caused by penknives and similar instruments; punctured wounds, by needles, pins, thorns, and splinters of wood; lacerated wounds, by gun caps, pieces of glass, particles of iron, and fragments of stone; and gunshot wounds by small shot discharged in hunting birds. Sometimes the cornea is ruptured by a severe blow or fall upon the eye. However induced, the injury is always attended with an escape of at least the aqueous humor, if not also of the lens and vitreous humor, thus greatly complicating the case, and often permanently injuring vision. Another accident, also frequently of a very serious nature, is prolapse of the iris, varying in extent, according to the size of the wound, from the smallest pin-head to nearly the whole membrane.

Wounds of the cornea, even when of considerable size, may easily be overlooked, especially when there is no separation of their edges, because of the liability of the membrane to preserve its normal appearance. In general, however, the nature of the case is recognized by looking at the cornea, as the eye, turned towards the light, is moved about in different directions, the lids being at the time held carefully out of the way.

Superficial abrasions, resembling the merest possible scratches of the skin, are now and then found upon the cornea, as the result of external violence; they involve simply the epithelial covering of the membrane, and are distinguished by the exquisite pain which attends them, which is often much greater than when the wound is deep and extensive.

The indications in wounds of the cornea are, first, to clear away foreign matter, and to replace the prolapsed iris or other internal structures; and, secondly, to control the movements of the organ, and moderate the resulting inflammation.

If a foreign body is imbedded in the cornea, it should be carefully withdrawn with the forceps; if it has passed beyond, into the interior of the eye, and is accessible, an attempt should be made to seize and dislodge it, lest, if permitted to remain, it should not only produce destructive inflammation, but become a source of suffering, for which it may be necessary at a subsequent period to extirpate the ball.

Replacement of the iris is best effected with a delicate probe, the patient, especially if a child, being under the influence of chloroform. The surgeon, availing himself of the temporary calm, restores the prolapsed membrane, and carefully adjusts the edges of the wound, which generally unite by the first intention, leaving little, if any, defect in vision. The influence of atropia or Calabar bean in dilating or contracting the pupil may enable us to remove the iris from the wound and thus prevent the subsequent prolapse. If the lens becomes opaque, in consequence of involvement in the lesion, the case is afterwards treated as one of ordinary cataract.

The second indication is fulfilled by the closure of both eyes by the bandage, excluding the light from the room, and employing the antiphlogistic regimen. A full anodyne is administered immediately after the accident. The patient must be closely watched, and, if plethoric, blood should be abstracted by the lancet and by leeches, taking care, however, not to carry the depletion too far, lest it should interfere with the reparative process.

2. *Inflammation*.—Corneitis, delineated in fig. 156, is characterized by a hazy state of the surface, and a zone-like appearance of the vessels at the periphery of the cornea, which is often quite vascular for the distance of nearly a line beyond this point. The vessels are greatly engorged, yet so extremely delicate as to render it difficult to distinguish them without the aid of a magnifying glass. The conjunctiva, iris, and sclerotica usually participate in the morbid action, and hence the case is apt to exhibit the characters common to inflammation of all these structures. The opacity of the cornea begins at an early period of the disease, and sometimes extends over the whole surface of the membrane, although, in general, it is more distinctly marked at some points than at others.

The pain of corneitis is severe, and is seldom limited to the inflamed membrane, but extends to the other structures of the eye, the orbit, temple, cheek, and forehead. Hemicrania is often a marked symptom. The eye is exceedingly intolerant of light, and there is abundant lachrymation, although there is but little secretion of mucus, or discharge of muco-purulent matter. When the inflammation is unusually violent, there may be constitutional involvement, as indicated by fever; but, in most cases, there is an absence of general derangement. The characteristic phenomena are the opacity of the membrane, and the zonular arrangement of the vessels at its circumference. In iritis, the vascular zone does not extend quite so far forward; hence there is always a narrow ring of comparatively healthy sclerotica between it and the cornea.

The causes of corneitis are various, and often difficult of recognition; in most cases, the disease is induced by external injury, or by a scrofulous taint of the system. The eruptive fevers, as measles, scarlatina, and smallpox, are frequently followed by a bad form of corneitis. In rheumatic and syphilitic scleritis, the cornea is very apt to participate in the morbid action.

Corneitis may terminate in resolution, the haziness and vascularity of the affected tissues gradually disappearing; or it may pass into the chronic state, with opacity; or, finally, it may lead to suppuration, ulceration, or gangrene.

In the *treatment* of corneitis, care must be taken not to carry the antiphlogistic measures too far. Unless the action is extremely violent, there will rarely be occasion for the use of the lancet, or of leeches, the disease generally yielding to gentle, but steady, purgation, abstinence, the antimonial and saline mixture, and the exclusion of light. The eye is kept quiet by anodynes, given in full and repeated doses, and by the use of atropia locally.

When the disease is of a strumous nature, the best remedy is quinine, along with a very minute quantity of antimony and opium, steadily persevered in for many weeks. When there is an anemic condition of the system, the quinine may be advantageously combined with some preparation of iron, as the iodide, sulphate, or precipitated carbonate. When the inflammation is plainly of a rheumatic origin, colchicum will be indicated, and should be used in the same manner as in scleritis. The syphilitic form of the disease is treated with mercury and opium, either alone, or in combination with iodide of potassium. Inflammation of the cornea dependent upon measles, scarlet fever, and smallpox, should be treated with mild means, as poppy fomentations, tonics, especially quinine, anodynes, and a supporting diet. When corneitis, however induced, becomes chronic, benefit will accrue from change of air, tepid bathing with salt water, tonics, and gentle, but steady, counter-irritation.

3. *Syphilitic Corneitis*.—In syphilitic iritis, the cornea frequently participates in the morbid action, but there is a form of inflammation, the result of a syphilitic taint of the system, in which, as was first satisfactorily explained by Mr. Hutchinson, of London, the disease is, in great degree, limited to this membrane. The subjects of the inflammation are children and young persons from five to eighteen years of age, with coarse, flabby skin, pits and scars on the face and forehead, cicatrices of old fissures at the angles of the mouth, and a peculiar depression of the bridge of the nose. The permanent teeth are of

Fig. 156.



Corneitis.

Fig. 157.



Syphilitic Permanent Teeth

a bad color, remarkably small and stumpy, and vertically notched at their edges. These changes, as seen in fig. 157, are most conspicuous in the upper incisors, but are also observable in some of the other teeth, especially the canine. The history of the attack usually shows that the eldest child is the sufferer, and that well-marked symptoms of inherited syphilis existed during infancy, such as sore mouth, cutaneous eruptions, chronic snuffles, and ulcers about the anus.

The earliest evidence of this affection is a diffused haziness of the cornea, like that of ground glass. White specks soon appear, not upon the surface, but deep in the substance of the cornea, and gradually increase in opacity. The conjunctiva and sclerotica show originally little, if any, augmented vascularity, but, in time, they become engorged, and a delicate plexus of vessels extends over the cornea, into the inflamed tissues, particularly along the upper and central portions of the membrane. The vessels are small, closely set, and deeply situated, not superficially, as in granular disease and other forms of ophthalmia. No tendency to ulceration manifests itself. The affection usually begins in one eye, but ultimately, generally in six or eight weeks, extends to the other.

The treatment essentially consists in the exhibition of iodide of potassium or iodide of ammonium with bichloride of mercury, quinine, bark and iron, an occasional laxative, a generous diet, and gentle exercise in the open air. Ptyalism must be carefully avoided. The opacity is generally very obstinate, and a long course of medication is required for its removal. A slight degree of haziness usually remains, despite our best directed efforts.

4. *Abscess*.—An abscess of the cornea is an occasional consequence of acute inflammation, especially of the traumatic and variolous forms; it is also met with, but much less frequently, in the strumous variety of the disease. The matter may be situated immediately beneath the epithelial covering of the cornea, but more commonly it is found in its substance, nearly equidistant from its two surfaces, not in a distinct, circumscribed cavity, as the term abscess would imply, but as an infiltration among the softened and disorganized fibres of the membrane. The matter, which is of a yellowish hue, is not true pus, but a mixture of pus and lymph, and hence it is always remarkably tough and viscid. The suppurative process is generally limited to a particular portion of the cornea, usually the central or inferior, but now and then it is spread over its whole surface.

The formation of matter is denoted by a yellowish appearance of the cornea, and by a marked aggravation of all the local symptoms. As the fluid accumulates, the cornea becomes more prominent, and finally yields at the most diseased part, where an imperfect escape of pus occurs. It is not always that the abscess points externally; on the contrary, it frequently bursts, and discharges itself into the aqueous humor.

Suppuration of the cornea, unless extremely slight, is one of those untoward circumstances the effects of which are never entirely removed; indeed, when the quantity of matter is considerable, the resulting opacity generally eventuates in total blindness. Hence, the practitioner should spare no pains to prevent its occurrence. If the patient is plethoric, depletion may be called for; but the reverse may be the case; he may be pale and exhausted from suffering, and then stimulants and tonics, as quinine, or bark and iron, with nutritious food and drink, may be proper. Much judgment will, therefore, be required to enable us to save structure and function. Locally, none but the blandest remedies should be employed. Puncture of the abscess may be had recourse to in the event of the matter being concentrated, to afford an opportunity for gradual drainage; but under opposite circumstances it will be well to let it alone, trusting to the operations of nature.

When the abscess bursts both externally and internally, there will be a gradual collapse of the anterior chamber; the iris will fall forwards against the cornea, and vision will be greatly impaired, if not completely lost.

5. *Gangrene*.—Gangrene of the cornea is a frequent occurrence. It is most common in persons of a delicate, feeble constitution, after the operations for cataract, and the more severe forms of ophthalmia, especially those consequent upon smallpox and the contact of specific matter. It is often produced by escharotic substances. Chemosis, a disease previously described, is very liable to produce gangrene of this structure, unless the greatest care is taken in its treatment to prevent the strangulation of the vessels of the cornea. When this event is about to take place, there is a great and rapid increase of opacity, and the membrane soon assumes a sodden,

macerated, and corrugated appearance. The local symptoms suddenly increase, but as the gangrene spreads the pain usually very sensibly diminishes in intensity. A deposit of pus often precedes the occurrence of gangrene.

When gangrene is threatened, all depletory measures must, as a general rule, be at once abandoned, and the patient put upon tonics, stimulants, and good, nutritious diet. The cornea should be touched every six or eight hours with a weak solution of nitrate of silver, consisting of about two grains to the ounce of water, and the system kept under the full influence of opiates, to quiet the eye and to promote sleep. If mercury was previously used, it should immediately be discontinued, as it cannot fail to do serious harm, by still further depressing the system.

6. *Ulceration*.—Ulceration of the cornea is a very common result of inflammation, both of the traumatic and specific kind. It is a frequent consequence of the lodgment of a foreign body, and a sequel of strumous, variolous, morbillous, and other forms of ophthalmia. The peculiarity of its structure, indeed, renders this membrane very liable to this morbid action; it bears a very close resemblance to articular cartilage, and the slightest causes sometimes lead to its erosion. Disease of the fifth pair of nerves is a cause of ulceration of the cornea. It is probable that the protracted use of unwholesome food may induce the affection by producing an impoverished state of the blood; a condition of the system ill calculated to resist the effects of inflammation. Once set up, it is often difficult to arrest its progress, and to prevent the formation of disfiguring and injurious cicatrices. The disease may occur at any period of life, and under almost every variety of circumstances as to constitution and health, but is most common in young subjects of a feeble, delicate organization.

Ulcers of the cornea assume every possible form and size, so much so, indeed, as to render it very difficult to furnish any accurate description of them. The most common variety, perhaps, is that in which the part has an excavated appearance, as if a solid portion of the cornea, comprising several of its layers, had been scooped out. In other cases the ulcer looks like a superficial abrasion, involving merely the epithelial investment of the cornea. Whatever form the ulcer may assume, its edges are generally somewhat everted, and more or less irregular, if not ragged, as may easily be seen by a careful inspection with the aid of a glass. It is seldom that they are inverted or undermined. In general, the ulcer has a slight hazy appearance, especially when cicatrization is about to begin, or has already made some progress.

Ulcers of the cornea are usually attended with pain, lachrymation, and intolerance of light, and more or less vascularity of the diseased structures. If their progress be not checked, they extend in depth until they cause perforation of the membrane, escape of the aqueous humor, and prolapse of the iris. They are apt to lead to incurable opacity, as a natural result of the reparative process, especially when the erosion has been extensive.

Unless care be exercised, an ulcer of considerable size may exist upon the cornea, and yet entirely escape detection. To conduct the examination in a proper manner, the surgeon should stand behind the patient, as he sits with his face fronting the window. The eye being now depressed, while the lids are held out of the way, the light will fall upon the cornea, and disclose any breach that may exist upon its surface.

The *treatment* of ulceration of the cornea requires great judgment and alacrity. Under an idea that the disease is generally one of overaction, the plan commonly pursued is to deplete the patient, if not by the lancet, at least by leeching and purgation, to a point beyond what is proper for the restorative process. The consequence too often is that the disease is aggravated instead of being relieved. Experience has shown me that, in nearly every instance, the affected part will be immensely benefited by an invigorating plan of treatment, consisting of the liberal use of quinine, or quinine and iron, along with a generous diet, and a full anodyne at least once in the twenty-four hours, especially if there be much pain. When the system is plethoric, and when there is an unusual degree of vascularity of the cornea and other structures, a few leeches applied occasionally to the neighborhood of the outer canthus, and the steady, but moderate, use of the antimonial and saline mixture, with a grain or a grain and a half of quinine to every dose, will go far in putting a speedy stop to the disease.

As it respects direct applications, the fewer are made, as a general rule, the better. Under the means just pointed out, the reparative process usually proceeds very kindly, and, unless the breach is uncommonly large, little opacity may be expected.

It is only when there is a disposition in the ulcer to extend, or when it has a foul, unhealthy aspect, that local remedies are called for, and even then they should be as mild and soothing as possible. One of the most eligible is a solution of nitrate of silver, in the proportion of two to ten grains to the ounce of water, applied directly to the sore by means of a very small camel-hair pencil, once a day, or every other day, according to the exigencies of each particular case. A very dilute ointment of the oxide of mercury also answers a good purpose. When the ulcer is of an unhealthy, phagedenic, or sloughing character, its surface may be touched with a stronger solution of nitrate of silver, or this article may be applied very gently in substance, shaped to a very minute point.

7. *Opacity.*—Opacity of the cornea exists in various forms and degrees, from the smallest visible speck to a patch large enough to cover its entire surface. A hazy appearance of the membrane is present in almost all cases of corneitis, however

Fig. 158.



Opacity of the Cornea; an Example of Albugo.

slight. The more marked and concentrated forms of opacity are generally the result of the cicatrization of deep ulcers and badly healed wounds. When the opacity is slight, it is usually designated by the term *nebula*, literally signifying a cloudy condition of the part; the hard, white, milky, concentrated spot, on the contrary, is known by the name of *albugo*, represented in fig. 158. The distinction between *nebula* and *albugo* has a real, practical significance; the former often disappearing spontaneously, or under very simple measures, whereas the latter seldom wholly subsides, whatever treatment may be adopted. *Nebula*, as it usually presents itself, is situated either in the epithelial investment of the cornea, or immediately beneath it, in the superficial layer of this mem-

brane, and often occupies a large extent of surface. *Albugo*, which frequently embraces the entire thickness of the cornea, is generally very hard and dense, white, or milky in its appearance, and of a circular, linear, or angular shape, its surface being sometimes smooth, at other times rough. It is essentially an analogous tissue, but so imperfect a copy of the original that it can hardly be said to bear any resemblance to it. Finally, cases occur in which this substance is partially transformed into fatty matter, fibro-cartilage, cartilage, or even bone.

The slighter forms of corneal opacity often disappear with the inflammation that has produced them, or within a short time afterwards. Should the case prove tedious, or not proceed satisfactorily, measures must be taken to promote the removal of the effused matter, among which the best are a solution of acetate of zinc, nitrate of silver, or sulphate of soda, or a very weak ointment of calomel, or of red oxide of mercury. I have derived great benefit, under such circumstances, from a little thin molasses poured upon the opaque cornea once a day, and also from washing the eye night and morning with tepid water, rendered gently stimulating with a little common vinegar or salt.

For *albugo* in its aggravated forms, surgery holds out little prospect of relief; it is an organized tissue, part and parcel of the cornea, and no remedies, either local or general, can remove it. When the opacity does not affect the entire cornea, useful vision may occasionally be procured by constant dilatation of the pupil with *atropia*, and, when there is a portion of cornea sufficiently transparent, *iridectomy* may be performed, and an artificial pupil established.

8. *Staphyloma.*—Protrusions of the cornea are technically known under the name of *staphyloma*; they are an occasional effect of inflammation and external injury, and occur in every intermediate degree, from the slightest aberration of the normal shape to the most hideous deformity. Two principal varieties of the disease are usually recognized, the spherical, fig. 159, and the conical, fig. 160.

The immediate cause of *staphyloma* is a weakened and attenuated condition of the cornea, especially of its central portion, in consequence of which it is incapable of resisting the intraocular pressure. More or less opacity and a certain degree of abnormal vascularity attend the development of the disease, the progress of which is always tardy, several years usually passing by before it attains much bulk. The tumor is commonly of a conical form; and, as it proceeds, it gradually projects beyond the lids, separating them from each other, and descending towards the cheeks, its length varying from a few lines to several inches. That portion which

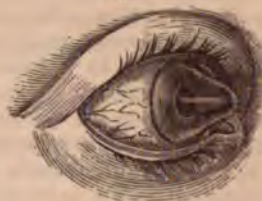
lies beyond the level of the lids is usually very hard, more opaque than the rest, and constantly inflamed from exposure to the light and the contact with irritants.

Fig. 159.



Spherical Staphyloma.

Fig. 160.



Conical Staphyloma.

When the disease is fully developed, the anterior chamber is annihilated, and the iris is not only lacerated, but closely adherent to the posterior surface of the cornea. Vision is always greatly impaired, and often completely destroyed. The staphyloma, after having attained a certain height, remains either stationary, or ulceration sets in, followed by perforation of the membrane, and the escape of the aqueous humor.

There is a form of this affection which involves both eyes, although rarely in an equal degree, being most common in young subjects, from the age of eighteen to thirty. The tumor is smaller than in the inflammatory variety, and also retains a greater amount of transparency, the opacity being generally limited to the part projecting beyond the lids. The iris preserves its normal position, the pupil moves with its accustomed freedom, and the anterior chamber, instead of being obliterated, as in the ordinary form of the disease, is only enlarged and changed in shape. Vision is more or less impaired, and the cornea is remarkable for its glistening, sparkling appearance.

In the incipient stage of staphyloma a gently antiphlogistic course is sometimes of service, if not in permanently arresting the disease, at all events in staying for a time its progress, and in preventing it from attaining any great development. The best remedies will be mild astringents, particularly the different preparations of nitrate of silver, ointment of the oxide of mercury, and solutions of zinc and lead, with frequent puncture of the cornea to take off the pressure of the aqueous humor. In general, however, these means fail, and the surgeon is compelled to resort to other measures, especially if the tumor has attained so much bulk as to be constantly irritated by the contact of extraneous matter. The most appropriate remedy in this case is excision of the cone, or of all that portion which projects beyond the edges of the lids. For this purpose, the lids being held carefully out of the way, the apex of the tumor is transfixed with a tenaculum, and the knife—a sharp, narrow bistoury—is rapidly carried from above downwards, cutting off the requisite amount at a single sweep. Care is taken not to remove too much, otherwise the eye may either collapse from the evacuation of its humors, or, at all events, shrink so much as to interfere with the wearing of an artificial one.

The operation introduced by Critchett for the relief of this disease is performed by passing four or five curved needles, armed with silk, through the tissues of the globe behind the base of the staphyloma, in a vertical direction, as in fig. 161, where the needles are seen in position. A puncture is then made into the sclerótica anterior to the plane of the needles, and with a pair of probe-pointed scissors an elliptical piece is removed, as indicated by the dotted lines. The needles are then in turn drawn through, and the sutures tied so as to approximate the divided edges as closely as possible. This affords a good support for the artificial eye by preserving a large por-

Fig. 161.



Critchett's Operation for Staphyloma.

tion of the globe. For the non-inflammatory species of corneal cornea there is no cure, but a careful iridectomy or iridesis may be done to improve the optical condition of the eye. Concave glasses alone, or combined with a diaphragm perforated with a circular or slit-shaped aperture, may greatly increase the vision.

9. *Fatty Degeneration.*—Fatty degeneration of the cornea is rather of pathological than of surgical interest, and, under the name of the senile arch, has been shown to consist essentially in a transformation of the horny tissue of the eye into a substance resembling fat. The altered part presents itself in the form of a gray ring, at the periphery of the cornea, near its junction with the sclerotica. The fatty transformation is not peculiar to the old, as the term senile would suggest, although they are undoubtedly most subject to it. It has occasionally been witnessed in children, and I have myself seen two cases of it before the age of twenty. It is often associated with fatty degeneration of the heart, arteries, liver, and other organs.

DISEASES AND INJURIES OF THE SCLEROTICA.

1. *Wounds.*—Wounds of the sclerotica may be of various kinds, as incised, punctured, and lacerated. They are, in general, easily recognized by their gaping appearance, caused by the retraction of their edges. When the sclerotica alone is divided, the bottom of the wound will be formed by the surface of the choroid, and will, consequently, present a black appearance. If this membrane is also divided, there will probably be a sac-like protrusion of the retina; and, should the lesion embrace all the tunics, there will necessarily be an escape of more or less of the vitreous humor.

Incised wounds of the sclerotica readily unite by adhesive inflammation, the plasma which fills the gap becoming speedily organized and transformed into an analogous tissue. To promote this occurrence, both eyes should be subjected to the most perfect repose, for at least a week, by confining the lids with strips of isinglass plaster, as after the operation for cataract and artificial pupil. The patient may remain in a dark room, be well purged, and live upon light food.

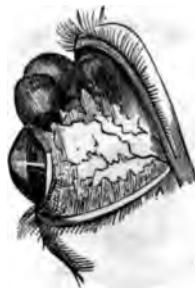
Laceration of this membrane may be caused by a blow upon the globe, when the rupture usually occurs at a point opposite to that to which the violence has been applied, by a sort of contre-coup, or excessive distension of the fibres of the tunic. Hence, its most common site is either the upper or inner part of the sclerotica, where injury is seldom or never inflicted, the nose and superciliary ridge serving to shield it. The rupture may be limited to the sclerotica, or it may involve the other tunics, and be attended with escape of the vitreous humor and of the crystalline lens into the subconjunctival cellular tissue. The treatment is the same as in an ordinary incised wound. If the lens is dislocated, it should immediately be removed by a small incision.

2. *Staphyloma.*—Staphyloma of the sclerotica signifies a tumor formed by the protrusion of this membrane beyond its natural level. The exciting cause is usually abnormal intraocular pressure, which produces atrophy, and, finally, excessive attenuation of the sclerotica, followed by a separation of its fibres and the protrusion of the other membranes of the eye. The affection is always accompanied by a dis-

colored and disorganized condition of the inner structures of the eye. The size of the tumor varies from that of a currant to that of a hazelnut; it may be rounded or ovoidal in shape, and has usually a bluish, purplish, or blackish appearance, from the presence of the pigmentary matter of the choroid. When the membrane is diseased at several points, there may be a corresponding number of protrusions, occurring either singly or in clusters. The annexed sketch, fig. 162, conveys an excellent idea of the situation, size, and shape of these tumors.

The prognosis of this affection is of the worst character; its very existence affords irrefragable evidence of incurable disease of the other structures of the eye; and hence treatment is advisable only in so far as it may be designed to relieve deformity. With this object, the removal of the tumor may be attempted by snipping off the most prominent portion, trusting to shrinking for the disappearance of the remainder.

Fig. 162.



Staphyloma of the Sclerotic Coat, seen in Profile.

3. *Sclerotitis*.—Inflammation of the sclerotica seldom exists as a pure, uncomplicated affection; most commonly it arises during the progress of other ophthalmic diseases, especially corneitis and iritis. As an independent lesion, it may be induced by various causes, of which the principal are exposure to cold, a rheumatic or gouty state of the constitution, and the action of the syphilitic poison. It is most common in middle-aged and elderly subjects, and winter and spring are its favorite periods of attack.

The *symptoms* are well marked. The pain is severe, throbbing, deep-seated, and liable to vesperal exacerbations; it usually extends to the forehead, temples, and upper part of the cheeks, and is aggravated by recumbency, and by the slightest motion of the eye, which feels full and tight, as if it were compressed by the hand. When the pain is less severe, the organ is sore and tender, or the seat of a distressing aching sensation. During the night, the suffering is often so excessive as to deprive the patient entirely of sleep, compelling him to sit up in bed, or walk the floor. In many cases there is hemicrania, or a dull, heavy, aching pain in the side of the head, with great tenderness on pressure. In some cases, again, the pain is of a neuralgic character, recurring in regular paroxysms once or twice in the twenty-four hours. The eye is intolerant of light, the smallest quantity generally proving a source of extreme suffering; and there is always an abundant secretion of tears, although usually very little discharge of mucus. Hence the edges of the lids either do not adhere at all, or only in a comparatively slight degree. If the eye be carefully inspected, it will be found that the discoloration is deep-seated, and of a faint bluish, pink, or lilac appearance, the vessels upon which it depends being exceedingly delicate, and disposed in parallel lines, converging towards the cornea, where they are very numerous and conspicuous, forming a well marked zone around its periphery, as in fig. 163.

The disease, in its earlier stages, is in great degree, if not exclusively, limited to the sclerotica; in a short time, however, it involves the other structures, especially

Fig. 163.



Scleritis.

Fig. 164.



Scleritis extending to the Internal Tunic.

the conjunctiva, cornea, and iris, as is seen in fig. 164. When this is the case, the ball of the eye often exhibits a bloodshot appearance; there is more or less haziness of the cornea, with an enlargement of its vessels; the pupil is sluggish, or entirely immovable, and the surface of the iris is altered in its color. The lids are rarely, under any circumstances, materially involved in the morbid action. Much diversity obtains in regard to the state of the constitution; in many cases there is an entire absence of fever, while in others it may be present from the beginning, and constitute one of the most prominent symptoms.

The *diagnosis* of scleritis is sufficiently easy, particularly in the earlier stages of the disease. The history of the case, the character and intensity of the pain, the excessive lachrymation and intolerance of light, and the peculiar nature of the vascularity of the affected membrane, cannot fail to enable the practitioner to distinguish it from other ophthalmic affections. In conjunctivitis, the discoloration is superficial, and of a scarlet hue; in scleritis, it is deep-seated, and of a pale pink, bluish, or lilac tint; in the former, the vessels are very large and arranged arborescently; in the latter, extremely small, almost hair-like, and disposed in straight, parallel lines, extending from behind forwards towards the cornea. Finally, in conjunctivitis, the vessels are movable; in scleritis, on the contrary, they are fixed.

The *treatment* must be influenced by the nature of the exciting cause, and the

actual condition of the system. The milder, non-specific forms of the disease will generally readily yield to active purgatives, light diet, and diaphoretics.

In *rheumatic* scleritis, the best remedies are colchicum and morphia, given in full doses early in the evening, and in small doses several times during the day. My usual practice is to administer a drachm of the wine of colchicum towards bedtime, with a grain of morphia, using a hot and slightly stimulating foot-bath immediately after, so as to induce copious perspiration. The next morning, about ten o'clock, half the quantity of these articles is given, or the dose may be still smaller, according to the tolerance of the system.

Syphilitic scleritis must be treated with calomel and opium, or some other form of mercury, carried to gentle ptyalism; or with the iodide of potassium, in doses of ten to twenty grains three times a day, combined with an anodyne, especially towards bedtime.

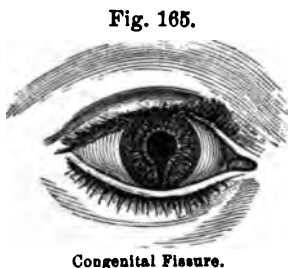
Solutions of atropia to the eye and anodyne liniments, embrocations, and unguents, applied freely to the forehead, cheek, and temple, are often of great benefit in scleritis, however induced; the use of medicated steam, directed upon these parts, will also be found very agreeable and soothing. In some cases, it will be necessary to take blood from the neighborhood of the inflamed organ by cups or leeches. As to counter-irritation, in all its forms, I am generally averse to it, for the reason that I have usually seen it do harm instead of good. This is especially true when it is applied to the temple, behind the ears, or even to the nape of the neck. It is less objectionable when applied to the arm, but even then it often fails to be of any material use in removing the morbid action. When scleritis becomes chronic, a mild course of alteratives and tonics will be necessary, aided by a properly regulated diet.

DISEASES AND INJURIES OF THE IRIS.

The iris is liable to various accidents and diseases, of which the most common are wounds, inflammation, adhesions, and morbid growths. The inflammation which assails it may be idiopathic, although this is exceedingly rare, or it may be caused by a rheumatic, syphilitic, or strumous state of the system.

1. *Congenital Vices*.—The iris is subject to congenital malformations, of which the most common are absence of the membrane and irregularity of the pupil. The former of these defects, termed *irideremia*, is necessarily attended with very imperfect vision, the eye, in ordinary light, being constantly disposed to roll about. In the only instance that I have ever seen of it, the child was nearly blind, and the interior of the globe, instead of being of a reddish tint, as usually represented by authors, was remarkably black. In some of these cases the iris is not completely absent, but exists in a rudimentary state, forming a narrow ring at the periphery of the cornea.

In a case of malformation which I saw not long ago, the pupil had the appearance of being double. It occurred in a man, twenty-eight years of age, whose sight was perfect although both eyes were in precisely the same condition. The pupil, which readily obeyed the light, was situated nearer the inner than the outer side of the globe, and occupied the inferior portion of the iris, extending down to the margin of the cornea. The more common variety is represented in the annexed sketch, fig. 165. The defect is called *coloboma of the iris*. The fissure is of a triangular shape, the apex extending downwards towards the ciliary margin of the iris. In rare cases, the pupil, although well formed, is not in its usual place.



Congenital Fissure.

2. *Tumors*.—A fibrous tumor, a melanotic sarcoma, or a cyst, idiopathic, or consequent upon traumatic injury, may be encountered, and will need for its removal, if benign, the ordinary operation for iridectomy, care being taken that the morbid growth is entirely drawn out previous to its excision; if malignant, extirpation of the globe must be performed.

3. *Mydriasis and Myosis*.—The movements of the iris are effected through the contraction of radiating or circular muscular fibres, the former under the control of the sympathetic nerve causing dilatation of the pupil, the latter animated by the third pair of nerves producing its contraction. Mydriasis or dilatation of the pupil ensues

upon paralysis of the third pair, whether induced by a central lesion, or by rheumatic, syphilitic, or other inflammatory disturbance of its trunk. It may ensue also from irritation of the sympathetic nerve, which may give to the radiating muscular fibres the power to overcome the antagonistic circular ones. Its treatment must depend upon its cause, or it may require to be general: locally, in chronic cases, a weak solution of Calabar bean may be used. To improve vision, if defective, a diaphragm with a small aperture may be employed, and a convex glass when the power of accommodation is also deficient.

Myosis signifies a contracted condition of the pupil, which may follow upon paralysis of the radiating fibres consequent upon severe injuries of the cervical portion of the spinal cord, or pressure upon the cervical sympathetic by an aneurism or a morbid growth. Locally, the instillation of solutions of atropia may be employed.

4. *Wounds*.—The chief interest which such lesions possess is that they are productive of serious inflammation, the plastic matter that is poured out being very apt to cause morbid adhesions, interfering more or less with vision. Sometimes the iris is torn off from its ciliary attachments by a blow or fall, leading thus to the formation of an artificial pupil; the opening, even if comparatively small, never closes; while, if it is at all large, it will seriously encroach upon the natural one, diminish its size, change its form, and cripple its action. Wounds are generally due to accident, and are caused by the penetration of the globe by sharp-pointed instruments, such as needles, scissors, or knives, which may also involve the lens, or by fragments of stone, iron, glass, and gun caps, which are liable to lodge in its substance, and give rise to destructive inflammation. Such foreign bodies require to be extracted as speedily as possible, together with any portion of the iris which has been bruised or lacerated, by means of the ordinary operation of iridectomy. Should the lens become opaque and swollen, or set up irritation by its pressure upon the iris, it should at once be extracted by the linear method, combined with iridectomy.

5. *Inflammation*.—Iritis may proceed from a variety of causes, of which the most important are, external injury, exposure, suppression of the cutaneous perspiration, a strumous, gouty, or rheumatic state of the constitution, and the operation of the syphilitic virus. It may be acute or chronic, and occur in both sexes, in every class of persons, and at all periods of life, even in young children. When it attacks the latter as an independent affection, the probability is that it is owing to a syphilitic taint of the system.

The disease frequently begins in a very insidious manner, there being often an entire absence of the ordinary phenomena of ophthalmia, such as discoloration of the superficial tunics, or severe local suffering. In general, however, pain is an early and prominent symptom, or soon becomes so; lachrymation and intolerance of light are also well marked. Unless the inflammation involves the conjunctiva, the disease

Fig. 166.



Acute Iritis.

may go on through its different stages, and even destroy the sight completely, and yet not occasion any considerable redness. The discoloration is limited usually to the sclerótica, at the corneal border of which there is always a distinct zone, as in fig. 166, formed by the vessels of the fibrous coat as they anastomose with those of the iris and choroid. This zone, which is never absent, is at first of a faint rose color, but afterwards, when the inflammation is fully established, of a deep red, cinnamon, or brick hue. At the beginning of the disease, there is a narrow ring of white between it and the cornea, but, as the morbid action advances, this is gradually lost by an extension of the vascularity. The

Fig. 167.



Iritis, showing the Characteristic Vascularity of the Globe, the Iris being clogged with Lymph, and the Pupil contracted and irregular.

The

vessels which produce the zone have a fine, hair-like appearance, with a radiated arrangement, and are seated beneath the conjunctiva, in the substance of the sclerotic, in which they are immovably fixed, as seen in fig. 167.

The pain of iritis is usually very severe and distressing, but cases occur where it is absent from first to last, although these are, of course, exceptional. Usually the pain is deep-seated, beginning apparently in the orbit, and rapidly involving the globe; becoming more and more severe and constant as the disease progresses; subject to violent nocturnal exacerbations; and generally, especially in the more confirmed stages of iritis, extending to the surrounding parts, particularly to the temple, eye-brow, and cheek. Sometimes there is the most violent hemicrania, along with photophobia.

The iris itself experiences most important alterations. Even at an early stage of the disease, it is already quite sluggish, while somewhat later it becomes insensible to light. Its anterior surface loses its fibrous appearance, and becomes rough and dull; and the pupil, diminished in size, is ultimately almost obliterated, at the same time it is observed to be deformed, and adherent to the capsule of the lens. In addition to these alterations, there is an extraordinary change in the color of the iris, contrasting strikingly with that of the healthy membrane. The morbid hue, usually somewhat greenish, is most conspicuous when the iris is blue; less so, when it is brown or hazel. Finally, the iris is often preternaturally convex, especially towards the circumference; the pupillary margin is greatly thickened; the aqueous humor is not only augmented in quantity, but rendered more or less turbid; and masses of lymph are frequently observed in the anterior chamber, either loose, or adherent to the diseased membrane.

When the disease is fully developed, the sight is either much impaired, or completely destroyed; for not only is the pupil greatly contracted, so as to interfere materially with the transmission of light, but there is often opacity of the cornea, or of the lens and its capsule, and also a disorganized state of the retina and choroid. Fever, often of a high grade, attends the earlier stages of iritis.

The distinction between the rheumatic and syphilitic forms of iritis, often obscure, will be best understood by the subjoined tabular arrangement:—

RHEUMATIC IRITIS.	SYPHILITIC IRITIS.
1. Usually coexists with rheumatism or gout.	1. With papular eruptions, sore throat, and other evidences of syphilis.
2. Most common in elderly subjects.	2. May occur at any age, even in infancy.
3. Often only one eye suffers.	3. Generally both eyes are affected; first one, and soon after the other.
4. There is little or no lymph in the anterior chamber and upon the anterior surface of the iris.	4. The plastic deposits are always prominent, often presenting themselves in the form of little, fleecy, vascular, reddish-looking tubercles, attached to the surface of the iris.
5. The aqueous humor is usually clear, or nearly so.	5. Generally turbid, often highly so.
6. The pain is nearly constant, though liable to exacerbations, especially at night.	6. Very bad at night, but almost, if not entirely, absent during the day.

The prognosis of iritis is grave, since, if allowed to progress, the disease is certain to damage the deep structures of the eye, more especially in the rheumatic and syphilitic varieties.

The *treatment* of iritis, when severe, must, in general, be antiphlogistic. Blood may be taken by cupping and leeching from the temples. The bowels should be thoroughly evacuated by cathartics, the heart's action controlled by sedatives, and pain allayed by the liberal use of anodynes. In the rheumatic form of the disease, colchicum proves a valuable adjuvant to the alkaline salts generally used. Whenever there is plastic exudation, as in the syphilitic form, mercury, carried to the extent of ptyalism, is the main remedy. The medicine should be given in full doses, its effects, however, being carefully watched, lest profuse salivation should arise. The best article is calomel, in doses of one grain every four hours, properly guarded with opium, and continued until the gums become tender, when it must either be withheld or administered in smaller quantities. When the calomel is tardy in its action, it may be assisted by mercurial inunctions; for, as already hinted, the object is to make as speedy an impression as possible upon the disease, in the hope of arresting the effusion of plastic material, which might plug up the pupil, and cause adhesions between the iris and the capsule of the lens. That it is well calculated to do this, expe-

rience has abundantly established, although we cannot explain the precise mode of its operation. Mercury, then, is the great remedy in this disease, the remedy par excellence, and should be given early and freely, until it has effected the object for which it is exhibited, when it may advantageously be followed by the iodide of potassium.

The effects of the remedies here mentioned may occasionally be aided by counter-irritation behind the ears or to the nape of the neck; but all direct applications should be dispensed with, except such as are of the most soothing character, as the steam of hot water and opium, fomentations, and light, medicated poultices. The circumorbital pains are often abated by anodyne embrocations, lotions, and unguents. Of the first importance is the early, frequent, and persistent use of atropia, which dilates the pupil, and thus removes the pupillary border of the iris from the convex central part of the lens, where adhesions are so certain otherwise to take place. A solution of four grains to the ounce should be thoroughly employed many times daily, by dropping it freely into the affected eye. Fresh adhesions may thus be stretched or broken, rest for the muscular fibres obtained, intraocular pressure diminished, and closure of the pupil, the main danger to sight, averted.

Should the iritis, in spite of all remedies, remain intense and intractable, complicated by firm adhesions and increased intraocular tension with great impairment of sight, a large iridectomy should at once be made. This will be found to be the best antiphlogistic, and the inflammation hitherto uncontrolled may rapidly subside.

I have no experience with the use of turpentine in the treatment of this disease, but have given it in several instances, apparently quite favorable for the appropriate action of the remedy, and have not been able to perceive that it has been of any benefit. In debilitated persons, in chronic cases, and in the latter stages of the acute attack, tonics may be demanded, as quinine and pyrophosphate of iron, in union with extract of *nux vomica*.

6. *Prolapse*.—Prolapse of the iris may be caused by wound, ulceration, or sloughing of the cornea, and may present itself in two varieties of form, the partial and the complete, of which the former is by far the more common. Complete protrusion of the membrane can only occur when there is most extensive injury of the anterior portion of the ball. Partial prolapse is usually produced by ulceration of the cornea, attended with perforation of all its lamellæ. The opening thus made is immediately followed by an escape of the aqueous humor, with protrusion of the iris, by which the gap is effectually closed. Plastic matter being effused, the prolapsed portion forms adhesions to the edges of the ulcer, the site of which is afterwards indicated by a black spot with a slight peripheral opacity. From the manner in which the iris is dragged out of its normal position, the pupil, except in the milder varieties of the accident, undergoes important changes in its form, size, and situation, attended with corresponding alterations of sight. When the displacement is considerable, vision may be completely destroyed.

The treatment must be regulated by circumstances, as it is impossible to lay down any particular plan for the guidance of the surgeon. In complete prolapse, depending upon extensive destruction of the cornea, the case is, of course, hopeless; if, on the other hand, it is caused by wound, the membrane should be immediately restored by means of a probe, and the lids kept well closed with a light bandage, until the parts have become thoroughly united. The success of the treatment will be greatly influenced by the care with which the replacement is effected; if the patient is a child, quietude should always be insured by the administration of chloroform, as it will hardly be possible to execute the procedure in a satisfactory manner without this precaution. The after-treatment is conducted upon strictly antiphlogistic principles.

When the prolapse is the effect of ulcerative perforation of the cornea, our hands are equally tied as in the complete form of the affection. To push back the iris, under such circumstances, would only lead to worse results; instead of this, therefore, the part is allowed to keep its place, for it is nature's plug, and is absolutely necessary to close the artificial opening, however much it may impair vision. This variety of prolapse is well illustrated in fig. 168. The protruded part projects beyond the level of the cornea, looking somewhat like the head of a small fly; whence the term

Fig. 168.



Prolapse of the Iris.

myocephalon, applied to it by oculists. When the iris protrudes through several apertures, it may give the surface of the cornea a black, tuberculated aspect, and may require retrenchment, in order to prevent injurious friction of the lids.

In the treatment of recent prolapse, dependent upon wound of the cornea, free use should be made of belladonna, or atropia, with a view of bringing the iris as speedily as possible under the full influence of the remedy. By dilating the pupil, the membrane is drawn away from the cornea, and is, therefore, less likely to be permanently intercepted by the edges of the wound.

7. *Synechia*.—This is the name given to an abnormal adhesion of the iris to the cornea and capsule of the lens, the term anterior being added to designate the former, and posterior to signify the latter. Anterior synechia is caused by wound, ulceration, or sloughing of the cornea; posterior, by iritis, and other diseases attended with plastic deposits. The lesion, in whatever form it may present itself, is always attended with impairment of vision, and occasionally with total blindness. Posterior synechia is often complicated with cataract. When the cornea and lens preserve their transparency, and the pupil is not completely obliterated, sight may sometimes be improved through the agency of atropia, and, at other times, by operation, the nature of which must be regulated by the character of the concomitant lesion.

8. *Obliteration of the Pupil*.—Obliteration of the pupil may be caused by the presence of plastic matter, filling up its aperture, either as an amorphous substance, or as an adventitious membrane, adherent to its edges. In the latter case, the affection constitutes what is termed a false cataract.

The treatment must be regulated by the exigencies of the case: when the obliteration is dependent upon the presence of organized lymph, an effort at its detachment may be made with a very delicate, double-edged cutting-needle, introduced through the cornea; or, when other means are unavailing, an artificial pupil may be formed.

IRIDECTOMY AND ARTIFICIAL PUPIL.

Iridectomy, or the excision of a portion of the iris, may be performed as an efficient antiphlogistic in some inflammatory conditions of the eye, or may be needed for the purpose merely of making an artificial pupil. Its marked influence in diminishing intraocular pressure recommends it in cases of ulceration of the cornea which threaten extensive perforation, or which, after perforation, are complicated by obstinate fistule, extensive prolapse of the iris, or marked and increasing staphyloma. In the extensive group of glaucomatous diseases, where there is an increase of ocular tension, followed by excavation of the disc and atrophy of the optic nerve, resulting

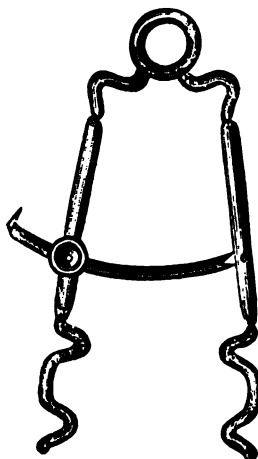
in entire blindness, this operation, at an early stage of the disease, affords the only hope of its arrest. It is also a proper procedure in those intractable and recurrent cases of iritis or irido-choroiditis complicated by circular synechia, which entirely occlude the communication between the anterior and posterior chambers. It is performed, also, in the excision of morbid growths, and in the removal of foreign bodies from the iris.

It would be profitless to describe the multitudinous operative procedures which have been proposed, but the one now recommended will avail either for the removal of a large piece of the iris in the conditions above mentioned, or, with slight modifications, for the establishment of an artificial pupil for optical reasons only.

The instruments requisite are a stop speculum to control the lids, a pair of toothed forceps for fixing the ball, and, when the incision is to be made inwards or upwards, angular, lance-shaped knives; broad needles, fine, curved forceps, blunt hooks, and delicate, curved or straight scissors, as depicted in the subjoined figures.

The patient should be placed in a recumbent position with the head slightly elevated. Unless strong reasons exist to the contrary an anæsthetic should always be given, since the slightest inadvertent movement of the patient's head or eyeball might turn the point of the knife against the crystalline lens, wound its capsule, and cause a traumatic cataract. The

Fig. 169.



Stop Speculum.

lids being fixed with the stop speculum, fig. 169, the surgeon seizes the ball below the cornea, by grasping the conjunctiva and the tendon of the inferior straight muscle with the toothed forceps, delineated in fig. 170.

Fig. 170.



Toothed Forceps.

A keratome, curved or straight, figs. 171 and 172, is then introduced through the sclerotica at a distance of half a line from the border of the cornea, and passed into the anterior chamber at its very periphery. The blade is carefully pressed forward on a plane parallel with that of the iris, until the incision is externally from two to two and a half lines in length. The knife is then slowly removed, to avoid any sudden escape of the aqueous humor.

Fig. 171.



Curved Keratome.

Fig. 172.



Straight Keratome.

Fig. 173.



Iris Forceps.

The fixation forceps should now be given to an assistant, to control the globe, leaving the surgeon free to employ both hands in the next step, which consists in seizing the iris with the delicate curved forceps, fig. 173—introduced, if requisite, through the incision—withdrawing it carefully, and excising it with the scissors, placed close to the globe. The point of election ordinarily is in the upper direction, when the iridectomy is made to antagonize inflammatory changes, and then it should be extensive, including a large segment of the iris.

Fig. 174.



Broad Needle.

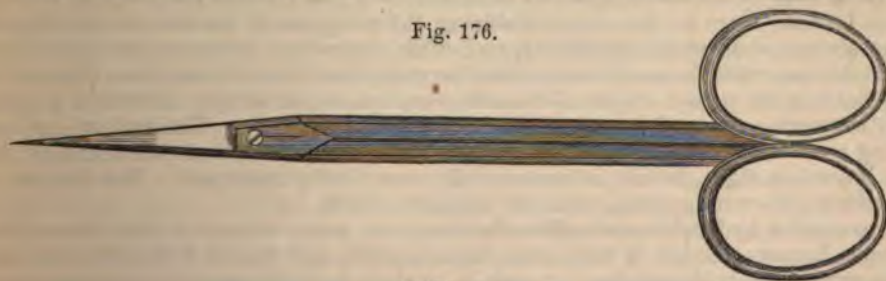
Fig. 175.



Tyrell's Hook.

When it is desirable to establish an artificial pupil for optical reasons only, the operator must satisfy himself that a portion of the cornea preserves its transparency

Fig. 176.



Iris Scissors.

and normal curvature, and that there is a percipency of the retina for light, as tested by the flame of a candle moved throughout the patient's field of vision. An incision may be carried through the cornea with the broad needle, fig. 174, and a blunt hook, fig. 175, passed into the anterior chamber, with which the iris is entangled at its pupillary border, withdrawn sufficiently from the incision, and excised with the scis-

sors, fig. 176. When practicable, the incisions should be so located as to leave a small peripheric portion of the iris intact.

As a substitute for iridectomy there is the operation of Passavant, devised for the reëstablishment of a pupil partially closed by adhesions, usually of a syphilitic character. An incision being made into the cornea with the needle, fig. 174, the iris

is seized with a pair of delicate forceps midway between its periphery and its pupillary margin, and an effort made at traction, which generally results in the laceration of some of the morbid adhesions. This procedure may be required to be repeated even a number of times.

Iridesis, introduced by Critchett, may be executed by passing a broad needle through the sclero-corneal junction, and placing around the incision a loop made of very fine silk, as indicated in fig. 177, through which a delicate blunt hook is carried to the inner border of the iris, a portion of which is then



Fig. 177.

Iridesis.

withdrawn, and, instead of being excised, is strangulated with the silk, the ends of which are seized by an assistant with ciliæ forceps and drawn tight.

A simple incision of the fibres of the iris will occasionally furnish a very satisfactory pupil, and it may be effected by means of the broad needle, affording the result depicted in fig. 178. The great danger of wounding the capsule of the lens and causing traumatic cataract must be fully considered.

Fig. 178.



Artificial Pupil.

By iridodialysis is signified a separation of the iris at its ciliary border, a procedure which affords occasionally a good result in cases of extensive opacity of the cornea, but where a peripheric portion of it remains transparent. A needle may be passed through the cornea, and with a delicate pair of forceps the iris may be grasped near its ciliary border, gently detached, and a sufficient portion withdrawn from the wound, and excised.

A knowledge of the methods described will enable the surgeon to make any modification that may be demanded in any peculiar circumstances. The after-treatment will be essentially the same as that required in operations for cataract.

DISEASES OF THE CHAMBERS OF THE EYE.

The only affections of the chambers of the eye requiring special notice are, drop-sical accumulations, effusions of blood, and the development of hydatids.

1. A morbid accumulation of water, constituting what is called *hydrophthalmia*, may exist simultaneously in both chambers, or be confined to one, more commonly the anterior. Dropsy of the anterior chamber is usually caused by inflammation of the membrane of Demours, a serous structure lining the cornea and the iris, both of which become more or less changed during the progress of the disease, the former being always abnormally prominent, and often somewhat nebulous, the latter dull and lustreless, with the pupil in a motionless and rather dilated condition. The ball is very hard in the earlier stages of the affection, but, as the dropsy advances, it generally becomes soft, and fluctuates distinctly under pressure. The patient, experiencing a sense of distension, but no pain, is annoyed by deceptive vision, and gradually loses his sight, which is occasionally completely destroyed. The disease is sometimes either congenital, or arises soon after birth.

In posterior hydrophthalmia, there is always, or nearly always, a fluid state of the vitreous humor; the eye is very large, hard, painful, and moved with difficulty; the sight progressively diminishes; the iris is pushed forwards into the anterior chamber; and the patient ultimately becomes completely blind.

The prognosis in hydrophthalmia is extremely unfavorable, especially in the posterior variety. An attempt may be made at relief by frictions around the eye with mercurial ointment, and the use of minute doses of calomel, with an occasional hydragogue cathartic, counter-irritation behind the ears, and repeated evacuation of the fluid by means of a small puncture of the cornea. Rational, however, as this

treatment apparently is, I have rarely derived any essential benefit from it. A large iridectomy may check the rapid enlargement, and preserve some vision; or extirpation of the ball may be required when the lids are insufficient to cover the protrusion.

2. In consequence of external violence, as a blow upon the ball, or spontaneous rupture of some of its vessels, an effusion of *blood* occasionally takes place into the chambers of the eye. In the female, it has been observed to occur as an effect of amenorrhœa, and in both sexes as a symptom of a scorbutic state of the system, attended with hemorrhage in other parts of the body. The fluid usually disappears in a short time by absorption; when the quantity, however, is inordinate, it may prove a source of irritation by its pressure upon the iris and cornea, and should then be evacuated by a small puncture through the latter membrane.

3. A species of *hydatid*, the cellular cysticerce of naturalists, is occasionally met with, in the anterior chamber, floating about in the aqueous humor. It has hitherto been observed exclusively in young subjects, mostly under fourteen years of age, without any apparent cause. The animal is about the sixth of an inch in diameter, and, as seen through the cornea, looks, when fully unfolded, very much like a miniature balloon, as exhibited in fig. 179, being semitransparent, and often quite brisk in its movements, retracting and protruding its head and body at pleasure. The consequence of the presence of such a body in the anterior chamber must, necessarily, be more or less impairment of vision, with a tendency to excite inflammation in the inclosing structures. On this account, it should promptly be removed by an incision through the cornea, the patient being under the influence of anæsthesia.

Fig. 179.



Cellular Hydatid.

The cysticerce is probably more common in Prussia than in any other country. During my visit to Berlin in 1868, Professor Von Graefe performed his one hundred and twenty-second operation for the removal of such a body from the eye. Professor Donders, of Utrecht, who, like myself, was present on the occasion, stated that he had never seen an example of it in Holland. In Great Britain, and in the United States, it is very rare, and its great frequency in Prussia is ascribed to the consumption of raw or uncooked pork by the people of that country.

DISEASES AND INJURIES OF THE CRYSTALLINE LENS AND ITS CAPSULE.

CATARACT.

Cataract is an opacity of the crystalline lens, of its capsule, or of both. In the first case it is called lenticular cataract, in the second, capsular, in the last, capsulo-lenticular. These distinctions are of great practical moment, as they exert an important influence upon the operations that are required for their cure. Cataract may be single or double, simple or complicated, traumatic or idiopathic, recent or old, mature or immature, congenital or acquired.

Of these different forms of cataract, the capsulo-lenticular is the most common. Whenever the capsule is at all seriously affected, the lens must also speedily suffer, although the converse of this may not be true, cases occasionally occurring where the lens is completely opaque, and yet the capsule retains its transparency. Traumatic cataract is always of the capsulo-lenticular variety.

Cataract is a very common disease, liable to occur at all periods of life, from birth to decrepitude, but the greatest number of cases are met with after the fiftieth year, or between that period and the sixty-fifth. Many cases also occur between the fortieth and fiftieth year. The disease is often congenital, and sometimes occurs in every member of the same family, as in an instance mentioned to me by the late Professor Drake, where as many as six children suffered in this way. Twelve years ago, a man brought to me three of his children, two sons and a daughter, on account of double cataract. Of his other six children, three were affected with strabismus. In another family, four children out of six were the subjects of this disease, two having been affected with it from birth. Dr. Thomas J. Kennedy, of Tennessee, has

communicated to me the particulars of a family consisting of six children, of whom three had congenital cataract. Of these, two were idiotic, and the other labored under harelip and cleft palate. Occasionally, again, the affection is hereditary, cases occurring in parents and their offspring for several successive generations.

Males are more frequently affected with cataract than females; but in what ratio has not been determined. The probability is that the number of cases would be nearly, if not quite, alike in both sexes, if both were equally exposed to the exciting causes of the disease; for it can hardly be supposed that the difference depends upon any other circumstances.

Causes.—Of the immediate causes of cataract very little is known. My belief has long been that the disease is generally developed under the influence of inflammation, leading to a change in the structure of the lens and its capsule. When cataract forms very rapidly, it is probable that these parts are affected with a species of senile gangrene, from obstruction of the central artery of the retina, thus cutting off the supply of blood, and producing a change of nutrition. What lends support to this view is the fact that opacity of the lens occasionally exists without any disease apparently of its capsule, whereas disease of the capsule, especially of its posterior segment, is always promptly followed by a change of color of the inclosed structure. It is well known that the capsule of the lens receives the ramifications of the central artery of the retina; and, although it is impossible to trace any of its branches into the lens itself, yet it is reasonable to suppose that some of them penetrate its substance. If we assume this to be the case, it is only necessary to imagine that these vessels are in a state of disease, and we shall thus have an easy explanation of the formation of cataract. When the vascular connection of the lens and its capsule is destroyed, opacity is inevitable. Of this occurrence we frequently see examples in injuries of the eye, attended with lesion or displacement of the lens, which are invariably followed by cataract, generally in a few hours. In old people, in whom cataract is so very common, the disease is probably the result of a species of atrophy, dependent upon the changes which affect all the tissues at this time of life.

However we may explain the manner of its formation, cataract frequently comes on without any assignable cause, the subjects of it being often in the most perfect health at the time of its appearance, as well as during its subsequent progress. Sometimes it is traceable to the effects of external violence, as a blow upon the eye, or injury upon the head. Wounds of the lens and its capsule, whether incised, punctured, or lacerated, are always followed by cataract. Violent inflammation, especially when it involves the deeper structures of the eye, frequently leads to this disease, along with some of its worst complications.

There are certain circumstances which are generally regarded, although, perhaps, not with sufficient reason, as so many predisposing causes of cataract. Thus, it is said that cooks, blacksmiths, foundrymen, and persons of kindred pursuits, are particularly prone to the disease. It is also supposed that sempstresses, watchmakers, and other artists, whose eyes are so constantly upon the stretch in viewing minute objects, are unusually liable to suffer from cataract. Without wishing to assert that these statements are wholly untrue, I have seen nothing to countenance them. Most of the cases of cataract that have fallen under my observation have occurred among farmers, mechanics, physicians, lawyers, and divines, who never injured themselves in this way, nor, so far as could be ascertained, in any other. Besides, the disease often occurs in infants and young children, at an age when such exposure is impossible. I have never seen cataract in a watchmaker, in a foundryman, or even in a literary man who sat up late at night by the flame of his lamp or gas-burner. I believe, therefore, that many of what are considered as predisposing causes of cataract exert no such influence, or only in a very remote degree.

There is no question that the condition of the general system often exerts a powerful influence upon the production of cataract. I have repeatedly noticed the disease in persons of broken-down constitution, and many cases have been published in which it was evidently caused by diabetes.

Cataract generally occurs in a very slow and gradual manner, several months usually elapsing before it exhibits its characteristic maturity. Occasionally, however, it is developed with great rapidity. A case in which a cataract formed in less than twenty-four hours was shown to me, in 1855, by Dr. John Bartlett, in an old man, a gardener by occupation. He first noticed that his sight was at fault in the

morning, while at work in his grounds; it grew gradually more and more dim, and before night it was totally extinct. The man was perfectly well at the time, but had lost the sight of the other eye by inflammation some years previously.

The disease may begin simultaneously in both eyes, or one organ may suffer for a time, and then the other may become affected in a similar manner. There are cases, however, and they are by no means uncommon, in which the cataract is limited to one eye, the other escaping altogether, even if the patient survive the occurrence a long while. It is generally supposed that, when one eye is cataractous, the other will, sooner or later, become cataractous also, in consequence of their sympathetic connection; such an explanation, however, is obviously altogether insufficient, and we shall probably be much nearer the truth if we ascribe the secondary affection to the same cause as the primary.

Morbid Anatomy.—Cataract varies much in its color, form, and consistence; so much, indeed, is this the case, that hardly any two instances of the disease are precisely alike.

The most common *color* of cataract is whitish, with various intermediate shades of grayish, yellowish, greenish, or brownish. The whitish appearance may be dull and lustreless, or of a shining, glistening, or pearly character, like the interior of certain shells, or the surface of a silver coin. A yellowish, cineritious, amber, or pale buff tint is sometimes observed, but not frequently. A greenish, olive, or bluish-gray hue is also rare, and is generally indicative of a complicated state of disease. A brownish cataract is very uncommon; and, as to the black variety of the affection, so much insisted upon by Beer and some other German authors, I have never seen an example of it, although its occasional existence is undeniable. The gold-leaf cataract, as it has been termed, also very infrequent, is characterized by its brilliant metallic aspect, caused by the presence of crystals of cholesterine.

The color of cataract is rarely uniform throughout the entire extent of the diseased structure; on the contrary, it is generally a shade or two darker at the centre than at the circumference. Cases occur in which the lens has a radiated, spoke-like, or stellar disposition, caused simply by the lines which produce this appearance being of a darker color than the intervening substance.

The capsular cataract is often a few shades lighter than the lenticular, and is also generally of a more uniform color. It has sometimes a speckled, dotted, or punctiform appearance. According to the researches of Dr. Stellwag, of Vienna, the opacity in this form of cataract is not seated in the substance of the capsule, but is deposited upon its internal surface. This matter, which can be detected only with the aid of the microscope, is either of an earthy or a fatty nature, and is the cause of the mottled appearance in capsulo-lenticular cataract.

In its *consistence*, cataract varies from that of milk to that of cheese, fibro-cartilage, cartilage, and even bone. A fluid cataract, properly so called, is very uncommon, and has usually a hard nucleus, especially when it is comparatively recent. The consistence of the lens may be equal to that of jelly, curds, a thick solution of isinglass, or the white of a soft-boiled egg. The hard cataract exhibits numerous varieties. Thus, it may be of the solidity of hard cheese, cartilage, bone, chalk, or earthy matter, and very dry, inelastic, and incompressible. Capsular cataract is generally more or less tough, especially when old, and indisposed to yield under the pressure of the needle. It is worthy of note that an opaque lens is usually a few shades darker in the eye than it is after it has been extracted.

The *size* of a lens, in a state of opacity, may be natural, augmented, or diminished. An increase of volume is most common in young subjects; elderly persons, on the contrary, have more frequently atrophy of the lens. In congenital cataract, or cataract coming on soon after birth, the lens is often completely destroyed, or so much wasted that it may be said to exist only in a rudimentary state. The capsule, in such a case, either retains its normal volume and shape, or it is shrivelled into a small, tough, and irregular mass, hardly as large as a currant.

A form of cataract, to which the term *lamellar* has been applied, was first noticed by Jaeger, and was afterwards well described by Graefe. A short but graphic paper on the subject was also published by my friend, Dr. E. Williams, of Cincinnati. It is most common in children under seven years of age, and essentially consists in a circumscribed opacity of a thin lamella of the lens, the periphery and central nucleus of which generally retain their natural transparency. Its progress is usually very

slow, and it frequently remains completely stationary for years, if not during the rest of life.

Cataract may exist as an independent affection, or it may be associated with other lesions. In the idiopathic form of the disease, the different structures are generally healthy; but when it has been caused by inflammation or external injury, it is often conjoined with disease of the cornea, iris, choroid, and retina, which thus seriously complicates the capsulo-lenticular malady, and exerts an unfavorable influence upon the prognosis. The general health may be perfectly good, or variously altered; and this circumstance, again, may materially affect the issue of our curative measures.

Symptoms.—Cataract usually manifests itself as an opaque speck immediately behind the pupil, in the centre or at the periphery of the crystalline lens, from which it gradually extends, until the whole of this body is of a whitish, milky, grayish, or drab color. Sometimes the affected part, instead of being distinctly opaque, has merely a nebulous appearance, as if it were suspended in the interior of the lens; at other times the opacity shows itself simultaneously at every point, although not with equal distinctness. The pupil is generally natural, and readily dilates and contracts under the influence of the light, its free margin forming a dark circle immediately in front of the cataract. The iris is unchanged in its shape, unless the diseased lens is unusually large, when it may be pushed a little forwards, and thereby rendered slightly convex. The cornea and aqueous humor retain their normal characters.

During the formation of cataract, the patient is conscious of impairment of vision, usually very slight at first, but gradually augmenting in proportion to the increase of the opacity of the lens and its capsule. He sees objects indistinctly, and, as it were, through a veil, haze, or mist; his sight is better in cloudy weather than in clear, and in twilight than in the bright sun, because the pupil, being then more dilated, admits a greater amount of light. In general, too, he can discern objects more distinctly by looking at them laterally than when they are placed directly in front of him. This is owing to the fact, already adverted to, that the opacity of the lens is generally greater at the centre than at the periphery, thus still permitting a certain quantity of light to come in contact with the retina. It is for the same reason that the sight is always temporarily improved by dilating the pupil with atropia. The formation of cataract is unattended with pain, intolerance of light, lachrymation, or disorder of the general health; and hence, but for the gradual loss of sight, the patient would not be at all aware of the existence of the disease.

In elderly subjects, the starting-point of the opacity is generally the nucleus of the lens, from which it gradually extends towards the exterior until the whole mass is involved in the morbid action. In congenital cataract, it nearly always commences at the centre of the lens, as a grayish-white, faintly striated object, the lines passing outwards towards the circumference. Sometimes the opacity originates as a minute dot, or a little obtuse cone, of a milky whiteness, in the superficial portion of the lens, just behind the capsule. Not unfrequently the whole lens is absorbed, its envelop alone remaining, usually, in a very shrunken, indurated condition. Cataract in children prior to the age of puberty is very uncommon; when it does occur, it is usually the result of injury, or of a congenital vice, which escaped the observation of the surgeon, the defective vision having been ascribed to the effect of shortsightedness.

Traumatic cataract is, at the beginning, nearly always cortical, but, in certain forms of injury, the opacity may occur simultaneously on the surface and at the centre of the lens. The disease, in either event, progresses very rapidly, and the lens, in young persons, brought in contact with the aqueous humor, is speedily absorbed, with the exception, perhaps, of a small portion, which, gradually undergoing the fatty and earthy degeneration, ultimately shrinks into a flattened, disc-like, mottled, or dead-white body, observable deep behind the pupil. The capsule, on the contrary, is seldom, if ever, completely absorbed; instead of this, it contracts firmly around the remnant of the lens, at the same time that it becomes very tough, and coated with earthy, fatty, and inflammatory matter. When the entire lens has been removed, the capsule generally rolls itself up into a hard, dense, white body, often of a ring-like shape, which either floats about behind the pupil, adheres to the iris, or sinks down into the posterior chamber, where it can be detected only when the pupil is widely expanded by atropia.

Diagnosis.—Cataract is liable to be confounded with amaurosis and glaucoma. From these, however, it may, in general, be readily distinguished by the following

circumstances, placed, for the sake of greater clearness and more easy reference, in tabular form:—

CATARACT.

1. Impairment of vision is gradual, several months generally elapsing before it is completely lost.
2. The opacity begins either at the periphery or at the centre of the lens; it is superficial, comparatively well defined, and of a grayish, whitish, yellowish, or pearl color. It is seen equally well, whether the eye be viewed sideways or directly from before backwards.
3. The pupil is natural, with a dark circle, and promptly obeys the influence of the light; it also readily expands under the application of atropia.
4. Vision is best in cloudy weather, in twilight, in shady places, and when the back is turned towards the light. It is also increased under the influence of atropia.
5. Cataract forms without pain, headache, intolerance of light, or constitutional disorder.
6. In cataract, there is merely a mist or haziness before the eye, with a distorted appearance of objects.
7. The sight is seldom entirely destroyed, however protracted the disease.
8. The expression of the countenance is comparatively natural and cheerful; the only perceptible change in the eye is the pupillary opacity.
9. The eyeball retains its natural consistence.

AMAUROSIS AND GLAUCOMA.

1. Vision fails rapidly, and is often lost in a few days or weeks; sometimes, indeed, in a few hours.
2. It begins simultaneously at different points, is deep-seated, diffused, indistinct, and of a bluish, greenish, or azure hue. It is seen most satisfactorily when we look directly into the eye, not laterally.
3. The pupil is widely dilated and insensible to light. It dilates slowly and imperfectly, if at all, under the influence of atropia.
4. The patient sees objects most distinctly in a bright light, and in a particular direction, owing to the fact that the retina often remains sound for some time at one or more spots. No improvement of vision follows artificial dilatation of the pupil.
5. In amaurosis and glaucoma, there is often, if not generally, hemicrania, with neuralgia in or about the eye, sick headache, and other marked evidence of gastric and general derangement.
6. In amaurosis and glaucoma, objects of grotesque appearance may float before the eye, and the patient is annoyed with scintillations or flashes of light.
7. Completely lost in the confirmed stage of the disease; prior to this, it is often alternately better and worse, in consonance with the condition of the general health.
8. The countenance has a singularly vacant appearance, and the eye looks as if it were dead.
9. In amaurosis and glaucoma, the ball is often very soft, so that it may almost be indented with the point of the finger, or of stony hardness.

Much stress was formerly laid upon the value of the *catoptric* test, as a means of diagnosis in cataract. It consists in holding a lighted taper before the eye, the pupil being previously dilated, and the examination being conducted in a dark room. If the cornea and lens are in a sound condition, three images will be perceived, two being erect, and the middle, or intermediate one, inverted. Of these images, the anterior is produced by the cornea, and is the most distinct; the posterior depends on the anterior surface of the lens, and is comparatively faint; the central is caused by the concave surface of the posterior wall of the capsule, and is the smallest of all. If the taper be moved, the two erect figures follow the light, but the inverted passes in the opposite direction. Now, in cataract, the middle one will be found, even at an early stage of the disease, to be very obscure, if not altogether absent, and the deep, erect one very indistinct. In pure amaurosis, the three images of the candle are quite distinct.

The diagnosis of cataract will be most easily made by means of oblique illumination and by the ophthalmoscope, facilitated by the application of atropia, which, by dilating the pupil, enables us to observe the condition of the lens, and to determine the site of the opacity, as well as its nature and extent. Useful information in regard to the consistence of the cataract may generally be obtained by a consideration of the age of the patient, the duration of the disease, and the color and size of the opaque body. The cataract of infancy is frequently capsular, or, if any portion of lens remains, it is quite small; in children and young subjects, the lens is generally soft; in elderly persons, on the other hand, it is nearly always hard. A very white or pearl-colored cataract is ordinarily soft; so, also, a cataract of unusually large volume. The very hard cataract is commonly small, and of a yellowish, drab, or amber hue. A recent cataract is generally soft; an old cataract, hard. To these

rules, however, there are, as might be expected, numerous exceptions, which should have due weight in the establishment of a correct diagnosis.

In congenital cataract both eyes are usually affected, and there is nearly always a peculiar oscillatory movement, termed nystagmus. This, however, may accompany ulceration and opacity of the cornea, and is, therefore, unreliable as a diagnostic. In encephaloid, the disease with which congenital cataract is liable to be confounded, the morbid growth begins in the retina, or, at any rate, deep behind the vitreous humor, and is invariably limited to one side.

Traumatic cataract is sometimes difficult of detection on account of injury sustained by the cornea, iris, and sclerotica; in general, however, the history of the case and the nature of the opacity will sufficiently indicate its character. When the disease is of long standing, the anterior surface of the cataract is occasionally covered by blackish specks, caused by a deposit of pigment from the posterior surface of the iris. Such an appearance, which might readily mislead an inexperienced observer, can only be detected by a careful exploration. A brown or black cataract is usually very difficult of diagnosis.

In capsular cataract, attended with complete destruction of the lens, the opaque membrane is generally remarkably shrivelled and irregular, and of a dead, chalky color; it is either partially adherent to the iris, as in the congenital form of the disease, or it floats about in the posterior chamber, as a small, dense body, often difficult of detection without the aid of atropia and a concentration of light by means of a convex glass. The posterior portion of the capsule is less frequently cataractous than the interior. Partial opacity may coexist with a healthy lens; but in the complete variety of the disease this body always participates in the morbid action.

What is called a *false cataract* is merely a layer of organized matter, which either completely fills the pupil, or is stretched from one point of its margin to another. The opacity is immediately within the pupil, which is generally contracted, and often immovable, even under the influence of atropia, and vision is more or less impaired, if not completely destroyed.

Treatment.—When cataract has once commenced to form, no remedies or mode of treatment can arrest its progress; on the contrary, it will be sure to advance until the opacity is complete, and vision is almost entirely lost. Should one eye alone be originally affected, the other is extremely liable to become affected also, whether from sympathy, or from the same causes which occasioned the disease in the first instance, experience has not determined. The result of operation, which alone can prove of any benefit in curing the disease, will be influenced by a great variety of circumstances, among which the most important are the state of the patient's health, the presence or absence of complications, and the amount of inflammation consequent upon the interference. Infancy and old age are no bar to surgical interference or its success; I have repeatedly operated, with the most happy effect, within the first six weeks after birth, and also upon subjects after the seventieth year. Indeed, in three cases I have succeeded in restoring excellent vision at eighty, eighty-two, and eighty-three. My opinion is that season exerts no special influence upon the result of the operation, and I, therefore, never postpone it on account of the state of the weather.

It is customary with surgeons in operating for cataract to subject the patient to a certain amount of preliminary treatment. This is particularly necessary in middle-aged and elderly subjects; not so much so in children and young adults; while in infants at the breast it may, in general, be altogether dispensed with. If the patient is otherwise perfectly healthy, it need not be carried beyond the observance of rest and light diet for a few days, and the administration of one or two very mild purgatives. When there is a rheumatic or gouty state of the system, or a tendency to inflammation of the eye, it is hardly possible to be too careful respecting the preliminary treatment. In general, it is advisable not to operate until it is certain that the secretions are in a healthy condition, and that all tendency to inflammation of the eyes has disappeared. If the individual is inordinately plethoric, he may take an active cathartic every other night for a week before the operation. When a gouty or rheumatic predisposition exists, a preliminary course of colchicum may be necessary, and, unless the case is very urgent, interference should be postponed until the arrival of warm weather.

It is a good rule not to operate so long as one eye only is affected, for the reason that, if violent inflammation should arise, it may extend to the sound organ, and

thus endanger the safety of both. Besides, even if there were no risk of this kind, which I think has been much exaggerated, be the result ever so favorable, the eyes, not being in the same optical condition, could not enjoy a similar amount of vision, although the patient might be rid of the opacity of the lens, and the consequent disfigurement of the part. Such are operations of expediency, and their performance is of questionable propriety. In case, however, cataract exists in both eyes, although in an incipient degree in one, the rule is to operate upon the bad eye first, and at some future period, when the sight shall have more declined, upon the other. What should be the rule of conduct when both organs are affected in an equal degree, or when the person is nearly or totally blind? This question has been answered differently by different writers. For my own part, I never hesitate to attack both eyes at the same sitting, believing that there is no more risk than when the operation is limited to one organ, while the procedure has the great advantage of obviating protracted confinement and mental anxiety. I do not think that I have ever had cause, in a solitary instance, to regret this step.

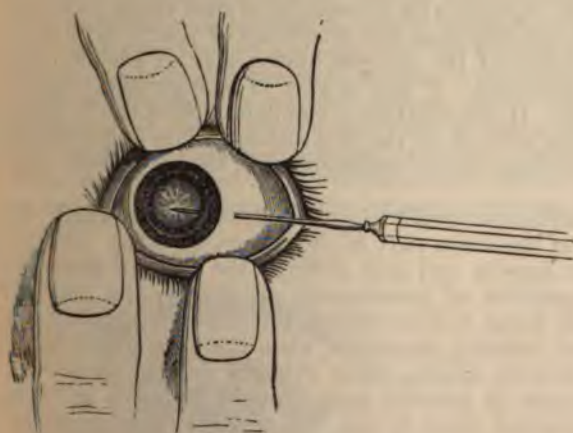
Before proceeding to any operation the surgeon should satisfy himself that the retina remains sensitive, and that the field of vision is of normal extent. This is done by placing before the patient, in a dark room, a lighted candle. He should be able to recognize the general position of the flame at the distance of fifteen feet, and it should not anywhere be lost to view when moved throughout the field of vision.

Although the *operations* which have been devised for the cure of cataract are quite numerous, they may all be referred to three principal methods, displacement, division, and extraction. As these methods are not equally adapted to all cases, much judgment is often required in regard to their particular application. Displacement, or couching, an old operation, was so constantly followed by destructive inflammation of the eye that it has become obsolete, although a brief description of it will be given as a matter of historical interest.

Division or solution is employed for soft cataracts, and in children; extraction is now performed for all forms of the disease in adults.

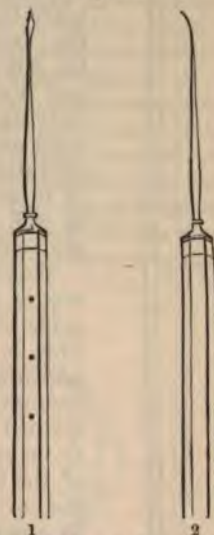
1. *Division of the Lens.*—Division of the cataract, or the operation by solution, consists, as the name implies, in cutting the opaque lens and its capsule sufficiently

Fig. 180.



Operation of Solution.

Fig. 181.

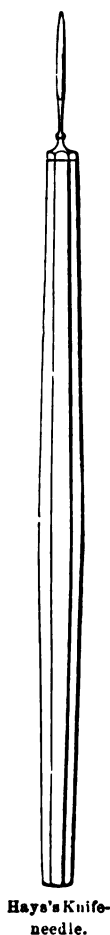
Scarpa's Needle. 1. Front view.
2. Side view.

to subject them to the influence of the aqueous humor. The pupil is thoroughly dilated by atropia, and the lids are disposed in the manner exhibited in fig. 180, the patient sitting upon a chair with the head well supported by an assistant. The needle which I generally employ is one of remarkable delicacy, perfectly straight,

and sharp-pointed. Some surgeons prefer a curved instrument, as that of Scarpa, represented in fig. 181; but I have not been able to satisfy myself that it possesses any advantage over, if indeed it is equal to, the straight. Whatever may be its shape and size, it should be introduced at least two lines behind the cornea, a little below the horizontal diameter of the eye, in order to avoid the long ciliary artery; the point should then be directed forwards in front of the lens and its capsule, into which several free incisions should be made. The object of the whole proceeding is to bring the opaque structures, after they have been properly divided, under the influence of the aqueous humor, and the more effectually this is done the more rapidly will they be dissolved. It is still a mooted point whether the aqueous humor really possesses any solvent power or not, or whether the disappearance of the cataract is not entirely due to the action of the absorbent vessels of the membrane of Demours. When we take into consideration the fact that pieces of cataract, both lenticular and capsular, which float about in the aqueous humor, often vanish in a very short time, without any but the most casual and transient contact with the structure here adverted to, it seems difficult to deny to this fluid such a property, although we may not be able to discover where it resides, seeing that it is composed essentially of water and a little saline matter, which are destitute of such properties out of the body.

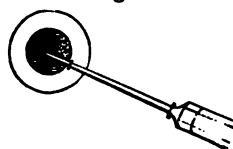
Dr. Hays, of this city, who has much experience as an ophthalmic surgeon, has devised an ingenious instrument for cutting up hard cataracts, and experience has shown that the operation is generally followed by the most gratifying results. The instrument, which is here represented of the natural size, fig. 182, combines both the

Fig. 182.



Hays's Knife-needle.

Fig. 183.



Keratonyxis.

advantages of a knife and a needle; it is very acute at the point, and has a double cutting edge, a little over four lines in length on one side, but much less on the other. The whole arrangement bears a very close resemblance to that of an iris-knife. The instrument is introduced in the usual manner, and brought in contact with the anterior surface of the opaque lens, which, together with its capsule, is then freely lacerated and divided in front, in order that the remainder of the body may be fully exposed to the action of the aqueous humor, and so become softened and ultimately absorbed. If this be slow in taking place, another operation is performed. If the cataract is comparatively soft, the whole of it may be completely divided at the first sitting. The pupil should be well dilated at the time of the operation, and, also, for some days afterwards.

There is another method of performing this operation, in which the needle is introduced at the lower part of the cornea, as in fig. 183, and made to act upon the capsule and lens through the anterior chamber. This is called the operation of *keratonyxis*, or, simply, the anterior operation. The pupil being widely dilated, the head and eyelids are secured as in the more ordinary procedure, when the cataract is freely divided with a very delicate needle, either straight or slightly curved, as many of its fragments as possible being brought forwards in front of the iris. The instrument must be inserted near the outer border of the cornea, so that the resulting inflammation, if severe, may not lead to any injurious opacity, interfering with the transmission of light. I have performed this operation only a few times, and the result was such as to induce me to form rather an unfavorable opinion of it, as I found it to be not only awkward of execution, but followed by too much excitement, at the same time that it does not possess, so far as I can perceive, any superiority over the posterior method.

In performing this operation, portions of hard cataract sometimes fall

accidentally into the anterior chamber, or are pushed there designedly, and cause injurious pressure upon the cornea in a manner similar to any ordinary foreign body. To save the eye, in such a case, from destructive inflammation, recourse should at once be had to linear extraction, by making an opening, not more than the sixth of an inch in extent, through the lower and outer part of the cornea. Removal of the offending substance is readily effected by the scoop or forceps.

The operation by solution is admirably adapted to the cataract of infants and young children. The patient, being under the influence of anæsthesia, is supported upon the lap of an assistant, or, what is preferable, his head is placed between the surgeon's knees, while the body and limbs are held by a second person. If the exhibition of chloroform is undesirable, the little child is wrapt up tightly in an apron, as in the operation for harelip. This precaution is indispensable to the success of the undertaking. In other respects, the proceeding is the same as in the adult.

The question is often asked, At what age is it proper to interfere in cases of congenital cataract? To this I unhesitatingly reply, at any period, provided the eye and general system are in a sound condition. I have repeatedly operated upon children under six months, and once upon an infant hardly four weeks old, with the most gratifying results. Indeed, my experience is that children, in general, bear this kind of meddling much better than grown persons, their nervous system, although easily shocked, recovering much sooner from the effects of the operation than adults.

The operation of *drilling*, devised by Mr. Tyrrell, of London, is a modification of keratonyxis, and is sometimes employed in false cataract, or in ordinary cataract attended with great contraction of the pupil, or contraction of the pupil and adhesion of its edges to the anterior surface of the lens. It is executed by carrying the common straight needle through the cornea, and thence on across the pupil, into the centre of the opaque lens, which is then perforated in such a manner as to admit the aqueous humor. The process is generally obliged to be repeated from four to eight times before a sufficient tunnel is obtained for the transmission of light for useful vision. Such an operation is of questionable utility, and might, I should suppose, be advantageously replaced, in every case, by the posterior procedure; for, besides the awkwardness attendant upon its performance, its frequent repetition is well calculated to lead to serious, if not destructive, inflammation.

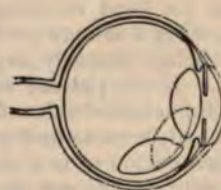
The method by *suction* will be found useful in cases of fluid cataract, or in ordinary cases of needle operation, when the lens has undergone a sufficient amount of softening. A tubular curette, having a piece of flexible india-rubber tube attached to its extremity, will be required. In suitable cases, a puncture should be made in the cornea, through which the curette may be passed, and any dissolved lens material may be withdrawn by suction by the mouth through the india-rubber tube.

2. *Displacement of the Lens*.—In the operation by displacement, more commonly called couching or depression, the lens is removed from the axis of vision, and buried in the substance of the vitreous humor. The pupil being widely dilated, the patient's head properly steadied, and the lids held out of the way, a curved needle, very delicate, and somewhat spear-shaped, is pushed across the coats of the eye, at least two lines and a half behind the cornea, and carried carefully forwards until the point becomes visible in front of the cataract, as in fig. 184. The point being now applied

Fig. 184.



Fig. 185.



Depression of Cataract.

against the lens, this is next pressed downwards and backwards into the vitreous humor beyond the axis of vision, and out of reach of the retina and the ciliary processes, as shown in fig. 185. The needle, being disengaged, is retained for a few

seconds in the eye, to ascertain whether or not the cataract is disposed to rise; if it is, it is again depressed, and now with still greater care.

To insure the successful execution of this operation, a certain degree of firmness of the cataract, and a tolerably healthy condition of the vitreous humor, are absolutely necessary. If the lens be soft, it cannot be depressed; and, on the other hand, if the vitreous humor be fluid, or partially dissolved, it will afterwards be impossible to prevent the lens from rising.

The result of depression is liable to be marred by the occurrence of retinitis; and the possibility of such a contingency is not limited to the first few days after the operation, but may take place a long time after the patient has completely recovered from its immediate effects. The cause of this occurrence is the pressure which the displaced lens exerts upon the retina and the ciliary processes, which inevitably excites inflammation, followed by complete disorganization of the eye. The lens, if not too hard, ultimately disappears after this operation, if not wholly, at least in part; but cases are met with, as dissection has demonstrated, in which it nearly all remains, much to the detriment of the part and system. For these reasons, the operation has been abandoned.

For many years past, I have been in the habit of performing a *mixed operation* for cataract, consisting of a combination of division and couching. The procedure, as the name implies, is executed by breaking up the outer and more fluid portions of the opaque lens, and burying the remainder in the substance of the vitreous humor. It is, consequently, not adapted either to the very soft or to the very hard cataract, but to a union of the two; an occurrence sufficiently frequent to render the operation one of no little importance. Not having preserved a record of my cases, I am not able to state how often I have performed this operation, or with what results; I am, however, positively certain that it has never been productive, in my hands, of violent, much less of destructive, inflammation, and that in nearly every instance the patient obtained good vision. The pupil is dilated, as in the ordinary procedure, and everything else is precisely similar.

I do not deem it necessary to describe the operation of *reclination*, as it is termed, a modification of the ordinary process of displacement, inasmuch as it is now obsolete. I have myself never performed it, but the cases of it that have fallen under my notice have all speedily terminated in total blindness.

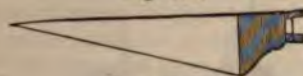
3. *Extraction*.—Extraction is a much nicer and more delicate procedure than that of depression or laceration; it requires great coolness and dexterity on the part of the surgeon for its successful execution. It is said of Wenzel that he spoiled a whole hatful of eyes before he had learned the art of extracting. This statement, without being strictly true, affords an excellent illustration of the difficulties which attend this operation, and a reason why so few practitioners are found who are ready and willing to undertake it.

When well executed, and all the preëxisting circumstances are propitious, it is the least objectionable operation of all; the whole of the opaque body is disposed of at a single sitting, the corneal wound generally heals by the first intention, and there is no danger either of immediate or secondary injury to the internal structures of the eye. On the other hand, if the greatest precaution is not exercised, there may be a sudden and unexpected escape of the different humors of the organ, followed by complete collapse, or the eye may be destroyed within the first few days by inflammation.

In performing extraction by flap operation, the patient may either sit upon a chair, with his head reclining against the breast of an assistant, and held perfectly quiet; or, what I always prefer, lie upon a lounge, sofa, or narrow bed, the head and shoulders being properly supported by pillows, so as to render the former almost horizontal. If the patient is very timid or nervous, I do not hesitate to place him under the influence of chloroform, satisfied that the risk of losing the eye by vomiting is an extremely remote and improbable one. The upper lid is raised by an assistant, with the precaution of not pressing upon the eye, while the globe is fixed by seizing hold of a fold of the conjunctiva a quarter of an inch below the cornea, with the instrument sketched in fig. 186, and which also depresses the lower lid. Or, instead of this, and what will answer quite as well, a pair of ordinary pocket forceps may be used, the nibs, which should be rather broad, being gently pressed against the sclerotica a short distance below the cornea. The eye is now drawn somewhat down, when the surgeon, armed with a Beer's knife, represented in fig. 187, to which I gene-

rally give the preference, inserts the point—supposing he is operating upon the left organ—into the cornea within a third of a line from its junction with the sclerotica, and a short

Fig. 187.



Beer's Knife.

distance below the horizontal equator. In executing this step of the operation, care must be taken to hold the instrument nearly vertically, otherwise it will pass between the

Fig. 188.



Superior Section of the Cornea.

Fig. 186.



Conjunctiva Forceps.

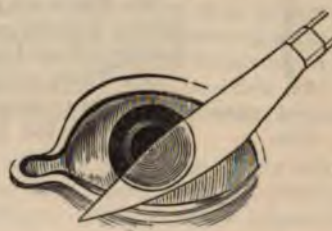
lamellæ of the cornea, instead of puncturing this membrane. Seeing now the point of the knife in the anterior chamber, it is carried carefully and slowly across towards the opposite side, in front of the iris, and brought out in such a manner as to divide fully one-half of the cornea, either at its upper, lower, or infero-external aspect, as may be most convenient; for, in point of utility, it really does not matter which, although the upper section is usually preferred. The extremity of the knife should issue at the same distance precisely from the sclerotica as that at which it entered. These several procedures are represented in figs. 188, 189, and 190.

Fig. 189.



Internal and Inferior Section of the Cornea.

Fig. 190.



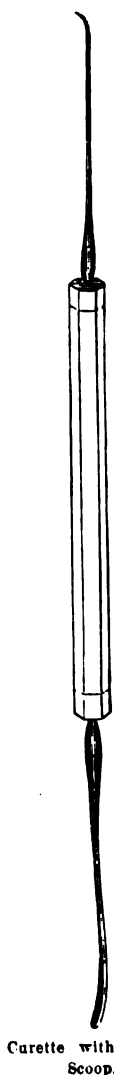
External and Inferior Section of the Cornea.

The section of the cornea being completed, the eye is immediately liberated, and permitted to conceal itself behind the lids, in order to enjoy a moment's repose.

The next step of the operation consists in gently elevating the upper lid, with a view of ascertaining whether the lens has any disposition to advance through the pupil. If it has, its expulsion is promoted by slight pressure upon the ball of the eye with the handle of a knife or the end of the index finger. Should this fail, the surgeon introduces a delicate hook, represented in fig. 191, and lacerates the central portion of the capsule; the lens, being thus liberated, now issues of its own accord, or at all events with the aid of a little friction upon the globe. Fig. 192 represents the lens as it is passing through the wound in the cornea.

The third and last stage of the operation consists in replacing the iris, should it be prolapsed, in readjusting the flaps of the cornea, and in confining the lids by means of several strips of isinglass plaster, with the twofold object of keeping them

Fig. 191.

Curette with Silver
Scoop.

quiet and of preventing the ingress of light. A light bandage, or, what is better, a very thin handkerchief, carried around the head, completes the dressing.

Fig. 192.



Lens passing through Incision of the Cornea.

Several accidents are liable to happen during this operation which should be carefully avoided.

1st. The point of the knife may become entangled in the iris in making the section of the cornea; should this happen, the instrument must be disengaged, but not withdrawn, and the iris stimu-

Fig. 193.



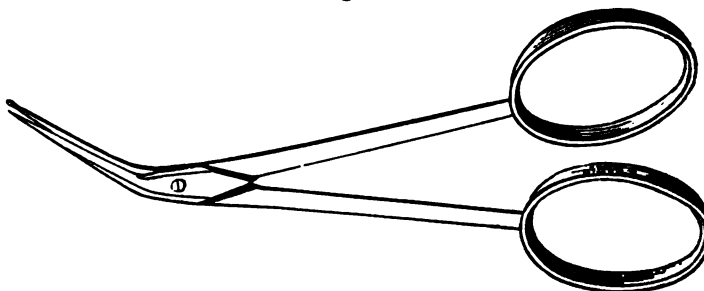
Curved Cornea Knife.

lated to contraction by gentle friction upon the cornea. This failing, the knife is laid aside, and the division completed with a probe-pointed bistoury, fig. 193, or a pair of scissors, fig. 194, one blade of which is blunt at the end. The flap, as already stated, should comprise fully one-half of the circumference of the cornea.

2d. There may be prolapse of the iris; this occurrence is by no means unusual, and is generally easily remedied, replacement being readily effected with a small probe.

3d. There may be an escape of the vitreous humor, followed by partial or complete collapse of the globe. This may be occasioned simply by the involuntary action of the muscles of the eye, and,

Fig. 194.



Probe-pointed Scissors.

therefore, be wholly beyond the control of the surgeon; or it may be caused by too free a section of the cornea, or by inadvertent pressure upon the globe. However induced, the eye should instantly be closed, and, after having a brief period of repose, the parts should be readjusted, as under ordinary circumstances.

4th. An opaque capsule may remain, the lens alone escaping, thus rendering the result imperfect. The proper plan, in such a case, is either to extract the capsule on the spot, or to dispose of it with the needle, when the eye shall have recovered from the immediate effects of the operation.

5th. The extraction is sometimes followed by intraocular hemorrhage, dependent upon the rupture of some of the vessels of the choroid. The blood is generally of a venous character, and, as it escapes, it usually displaces the vitreous humor, forcing it out of the eye, and thus completely defeating the object of the operation, besides inflicting severe suffering upon the patient. The immediate effects of the accident are faintness, nausea, and agonizing pain, seated deeply in the ball of the eye, and radiating through the forehead, nose, and temples, the lids being so exquisitely sensitive as to render the slightest touch almost insupportable. Inflammation, often of a destructive character, soon follows, and greatly aggravates the distress. The treatment should consist of cold applications to the eye, the copious abstraction of blood, and active purgation, with elevation of the head, the careful exclusion of light, and the free use of anodynes.

4. *Linear Extraction.*—This operation, devised by Gibson in 1811, modified soon after by Travers, and lately revived in Germany, consists in making a small incision through the outer and lower part of the cornea, from the eighth to the sixth of an inch in extent, in freely dividing the capsule and lens with a fine cutting needle, and in removing the fragments, after they have been brought into the anterior chamber, with a scoop. If thorough comminution has been effected, most of the fragments will probably be washed away by the aqueous humor, as it gushes through the wound; if not, they should be carefully extracted, unless they are very small, when they may be left in the hope of being speedily absorbed.

Linear extraction is, of course, applicable only to soft cataract, and recommends itself by the facility of its execution, the little risk of inflammation, and the rapidity with which it affords relief. Chloroform may be administered if the patient is unusually timid or unruly. Great care should be taken not to injure the iris or to contuse the edges of the wound in the cornea.

A modification of this operation, proposed by Von Graefe, was further perfected by Waldau, of Berlin, and has been more or less extensively practised in Europe and this country. It consists in making an incision through the cornea, close at its edge, for about one-third of its circumference, in drawing out and cutting off the corresponding portion of the iris, in tearing up the anterior segment of the capsule, and in extracting the lens with a delicate scoop. Care is taken not to wound the hyaloid membrane, lest there be an escape of its contents. A good deal of blood sometimes collects in the anterior chamber of the eye, and when this is the case it must be dislodged before the rest of the operation can be proceeded with. If the manipulations are properly executed, the entire lens may be removed in one effort. Any fragments that may remain are disposed of by the introduction of the scoop, and by gently rubbing the ball through the lids. This procedure is known as the traction method.

In the original operation of Waldau, a bit of the iris was left at the ciliary margin, to afford support to the vitreous humor; but it was soon found that the procedure greatly increased the danger of inflammation, without offering any compensating advantage, and it has, therefore, been abandoned.

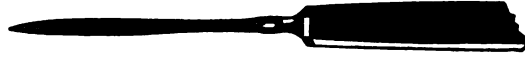
5. *Graefe's Operation.*—An operation which combines all the merits of the flap extraction and the linear method with traction, together with superior advantages of its own, was devised by Von Graefe, and termed by him the "peripheric linear extraction" method. His extended clinical experience enabled him to render each step of his operation so perfect that it is accepted by ophthalmic surgeons universally as the best now known. It is most readily described by dividing it into four stages: 1st. Incision; 2d. Iridectomy; 3d. Laceration of the capsule; 4th. Removal of the lens.

The instruments required are the stop speculum, fixation forceps, iris forceps, and scissors, described under the head of iridectomy, added to which are a capsule tearer, or cystotome, a caoutchouc spoon, and the narrow knife, which was considered by its inventor as the model best suited for his incision, shown in its real dimensions in fig. 195. Dr. Levis, of this city, instead of using a straight knife, prefers one with a convex blade, which I have often seen him use with admirable dexterity.

As the pain in the operation is not severe, and as it is very desirable that the

patient should give some assistance in moving the ball, if it should be found requisite, an anæsthetic should not be given if it can be avoided. The patient having

Fig. 195.



Graefe's Cataract Knife.

been placed in the recumbent position, the surgeon, if limited to the use of his right hand for his incision, must place himself behind the patient for his right eye, and at his left side for the operation on the left eye. Having secured the eyelids by means of the speculum, the surgeon seizes the conjunctiva, beneath the cornea, with the fixation forceps, and thus gains control of the ball; or, what is better, he grasps, as

Fig. 196.



Graefe's Corneal Incision.

is the practice of Dr. Levis, the inferior straight muscle. Holding the knife with its cutting edge upwards, he then introduces it at a point $\frac{1}{2}$ a line behind the corneal border and $\frac{1}{2}$ a line below an ideal tangent to the cornea at its apex, designated as *a* in fig. 196. The point of the knife should be directed towards *c*, until 3 or 4 lines of it have entered the anterior chamber, when its point is elevated, by depressing the handle; it is then carried to the point *b*, and a counter-puncture through the sclerotica is then effected. The edge of the blade is now turned

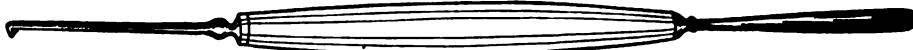
forwards, and the knife carried onwards until its length is exhausted, when the section is to be finished by drawing it backwards until all the tissues have been divided but the conjunctiva, which should be cut so as to leave a flap of not more than a line or a line and a half in extent.

If these steps have been exactly followed, the anterior chamber will have been opened at its periphery by an incision which shows little tendency to gape, and which will be from $4\frac{1}{2}$ to 5 lines in extent, and, although not strictly linear, yet giving a flap of $\frac{1}{2}$ line in height.

Confiding the fixation of the ball to an assistant, the surgeon, with the iris forceps, seizes the iris about 1 line from the temporal extremity of the cut, draws a portion of it out, and, with successive clips with the scissors, divides it at its ciliary attachment, and, gradually making the traction towards the nasal end of the incision, finally excises it there as closely as possible to the ball.

The fixation forceps being resumed by the operator, the anterior capsule is lacerated with the cystotome, fig. 197, which should be carefully passed to the lower

Fig. 197.



Cystotome, with Caoutchouc Spoon.

border of the pupil, when its sharp point should be turned against the capsule, which should be incised in a direction upwards and outwards; the point should be again passed to the same spot, and an incision upwards and inwards effected; these two should then be united by a transverse cut across the capsule, when the lens will probably be freed and will be seen to advance.

The surgeon still retains control of the ball, while, with the caoutchouc spoon, fig. 197, applied with its convex surface to the lower border of the cornea, he makes a pressure which has for its object the tilting of the upper margin of the lens towards the corneal incision. When this has been accomplished, a gentle upward motion of the spoon will cause the cataractous lens to emerge more and more, and finally to escape entirely from the wound. When this manipulation does not succeed,

Fig. 198.



Dr. Levis's Wire Loop.

the lens must be withdrawn by one of the traction instruments, the best of which is a delicate wire loop, fig. 198, devised by Dr. Levis. Should any cortical matter

or blood remain, it should be removed by gentle pressure upon the cornea with the spoon, or, after the withdrawal of the speculum and a little delay, by pressure and counter-pressure with the finger tips upon the closed lids.

All coagula having been removed, and the edges of the wound being in contact, the lids should be closed, and confined by a piece of soft linen, covered with small tufts of charpie or cotton, evenly distributed, so as to fill the orbital cavity, the whole being retained by a flannel roller passed thrice over the eye and around the head, care being exercised that no undue pressure upon the ball is made. The other eye should be closed with isinglass plaster.

Graefe was in the habit of removing the dressing late on the evening of the operation; but, unless there is much discharge or some unusual occurrence, this will not be necessary until the morning visit, after which it should be renewed once a day, the eyelids having been previously gently washed. At the end of a week it may be discontinued, and a shade, to exclude light, be substituted. Should there be pain severe enough to prevent sleep the first night, a subcutaneous injection of morphia may be administered.

After-treatment.—The after-treatment, in all these operations, is conducted upon moderately antiphlogistic principles. The light is carefully excluded from the apartment, the patient's head and shoulders are constantly maintained in an elevated position, the diet is of the mildest character, but rather nutritious than otherwise, and the bowels are occasionally relieved by a gentle aperient. If active inflammation arises, blood is taken freely from the arm, and by leeches or cups from the temples, blisters are applied to the inner surface of the arm, and the eyes are frequently fomented with warm chamomile tea containing a few drops of Goulard's extract and wine of opium. If there is much pain, especially of a neuralgic nature, calomel and opium, calomel and Dover's powder, or, what will be found more efficacious than either, wine of colchicum and acetate of morphia, are liberally employed. Depletion after these operations is not carried nearly so far now as formerly. After extraction, in particular, too much caution cannot be used in this respect, inasmuch as too great a drain upon the system might seriously interfere with the union of the corneal wound. When the patient is old or infirm, a nutritious diet and other means calculated to give tone to the system are indispensable to success.

The bandage may usually be dispensed with in a week or ten days, a green shade being used as a substitute. The eye must not be employed upon minute objects for several months, and the patient should consider himself for a long time as an invalid, avoiding all indiscretions, both bodily and mental. As the sight improves in strength, and all tenderness consequent upon the operation has disappeared, but not until then, he may begin to wear cataract glasses, of which he should furnish himself with two pairs, with lenses of different degrees of convexity, according as he may wish to view near or distant objects. The best lenses are made of pebble, as it is less liable to be scratched or broken than plate-glass. The frame should be very light, and consist of steel. Tinted lenses may be used when the eyes remain long weak and intolerant of light.

Much of the success which has attended these operations in my hands may, I think, be ascribed to the care which I have always taken in preparing the patient's system, and to the practice which I have pursued, for many years, of administering a full anodyne immediately after he has been put to bed. The article which I usually employ is sulphate of morphia, of which from half a grain to a grain may very properly be given, if the patient is an adult. This seldom fails to prevent pain, and to induce sleep, two circumstances of immense consequence as it respects the favorable issue of the case. If rest is of any importance in the treatment of inflammation, it surely ought to be of the greatest benefit when the disease affects so tender and delicate an organ as the eye; and I know of no means so well calculated to insure this end as a large dose of morphia, given in the way here specified. It is especially valuable in nervous, irritable persons, and in such as are liable to suffer from nausea and severe shock after trifling accidents and operations.

DISLOCATION OF THE CRYSTALLINE LENS.

Dislocation of the crystalline lens forwards into the anterior chamber, exhibited in fig. 199, is a rare occurrence. It may arise without any assignable cause, although generally it is chargeable to external violence, directly or indirectly applied.

A married woman, aged thirty-six, a native of Germany, had been laboring under dislocation of the lens for three years when I first saw her. The accident happened

Fig. 199.



Dislocation of the Lens into the Anterior Chamber.

suddenly one night without any pain or even any unpleasant feeling, apparently while she was asleep. The next day, however, she was seized with violent pain and inflammation, which lasted for nearly two months, when it gradually subsided. It is worthy of remark that she had had no sight in that eye for seven years previously. The lens lay in the lower part of the anterior chamber, in close contact with the cornea and iris, and was of a conical shape, the apex looking upwards; it was opaque inferiorly, but semitransparent above, and was so situated as almost to close the pupil. The cornea was natural, but the iris was tremulous, thrust back, or indented below, and changed in color, being much lighter than the right, which was of a grayish hue. The pupil was small and immovable. The sight was completely destroyed.

Another case was that of a colored woman, aged forty-nine; the right lens, which had been dislocated for four years, without any assignable cause, was of a dirty drab color, and occupied the anterior chamber; it rested against the posterior surface of the cornea, and pressed aside the iris, the pupil being

contracted into a narrow, slit-like aperture. The eye was completely blind, and had been the seat of neuralgia, off and on, ever since the accident, which was followed by severe inflammation.

This accident may result from very slight causes, as pressure upon the ball by the finger, the shock of a fall, or even sneezing. It is recognized by the sudden change in the optical condition of the eye, as well as by the presence of the lens, partially or entirely displaced, as ascertained by oblique illumination. The proper remedy for such an occurrence obviously is the extraction of the lens, with the employment of active antiphlogistic measures, to moderate and relieve the resulting inflammation. If the case is one of long standing, the operation would still be proper as a means of improving the appearance of the eye, and preventing secondary effects.

AFFECTIONS OF THE VITREOUS HUMOR.

The most important affections of this humor are foreign bodies, effusions of blood, entozoa, inflammation, opacity, and softening.

Foreign bodies, as fragments of gun caps, steel, and glass, sometimes penetrate the eye, and lodge in the vitreous humor, causing inflammation of its substance, along with more or less opacity, and loss of vision. Eventually the extraneous matter falls down into the lower part of the organ, and coming in contact with the retina and choroid coat, not only produces excessive suffering but complete disorganization of these structures. Detection is usually readily effected with the ophthalmoscope, if the examination be made soon after the occurrence of the accident, otherwise it may be difficult, if not impossible, as the foreign body is soon surrounded by a layer of fibrin, which thus serves to mask its character. Extraction is effected either through the sclerotic coat, or through the cornea, the lens, in the latter case, being of course removed as a preliminary step. The operation is not always successful.

Effusion of blood into the vitreous humor is caused either by external injury, as a

blow on the eye, or by a rupture of the vessels of the retina or choroid, more especially of the anterior portion of the latter, as this is more vascular than any other. The fluid is either extensively diffused, or, as not unfrequently happens, it occurs in circumscribed spots, of variable form and size, and of a dark reddish or purplish color. The traumatic variety is generally attended with partial detachment and laceration of the retina, or of the retina and choroid, and with ecchymosis at the bottom of the eye. The nature of the case is generally easily determined with the aid of the ophthalmoscope. If the blood exists in small quantity it will probably be rapidly absorbed, otherwise it may remain permanently, the clot gradually becoming pale, and undergoing fatty degeneration. The treatment is restricted to cold applications and the exhibition of iodide of potassium with minute doses of mercury.

The *cysticerce* has been found only a few times in the vitreous humor. Liebreich, who has given a graphic account of the parasite as it occurs in this portion of the eye, states that it is originally developed behind the retina, from which it at length escapes into the vitreous chamber, where, after it bursts its cyst, its movements may be distinctly seen with the aid of the ophthalmoscope. Although it does not at first cause any inconvenience, it ultimately excites inflammation of the eye, attended with more or less impairment of vision. Liebreich, in one case, not only detected the parasite but successfully extracted it by passing a pair of canula-forceps into the vitreous humor, the operation being greatly facilitated by illuminating the eye with an ophthalmoscope fastened to the forehead, leaving thus both hands free for the necessary manipulations.

Inflammation of the vitreous humor, technically called *hyalitis*, is a very uncommon affection, usually dependent upon the presence of foreign bodies, or upon injury inflicted upon the eye in operations for cataract. It is attended by deposits of fibrin, leading to opacity of its substance, and by marked impairment of sight. Sometimes the vitreous humor is completely dissolved during the progress of the disease, or interspersed with fatty matter, particles of cholesterine, or films of lymph, obstructing vision, and causing all kinds of fantastic objects, as motes, flies, and other insects, to float before the eye. A syphilitic form of *hyalitis* is occasionally met with, either as an inherited disease occurring about the age of puberty, or as a tertiary accident, usually coexistent with other evidences of a constitutional taint. However induced, the morbid changes can only be detected by careful ophthalmoscopic inspection. The treatment must be managed upon general principles.

The vitreous humor is liable, from various causes, to lose its *consistence*, breaking down into a fluid state, which is not, however, necessarily attended with loss of transparency and diminution of the tension of the eyeball. External injury, surgical operations, and inflammation of the choroid coat, retina, and hyaloid membrane are the most common causes of this occurrence, for which there is, of course, no relief.

Mr. Macnamara, of Calcutta, in his excellent Manual of the Diseases of the Eye, has described a curious condition of the vitreous humor, called sparkling *synchysis*. It is dependent upon the presence of innumerable particles of cholesterine, which, under the ophthalmoscope, "appear like a multitude of grains of gold-leaf, whisking about in all directions when the eye is turned quickly from one side to the other." The material generally arises, he thinks, from degenerative changes in a dislocated lens, a great portion of which is absorbed, while the insoluble cholesterine is left in the vitreous humor.

DISEASES OF THE RETINA.

The retina, like the other tissues of the eye, is liable to inflammation and its various consequences, leading to disorganization of its structure and to loss of function. The disease, at one time, is acute and characteristic, being marked by symptoms which no one can possibly mistake; at another, slow, chronic, and so obscure as to elude scrutiny; now transient and easily combated; now inconceivably obstinate, and hopelessly irremediable. Considering the delicate structure of the retina, its concealed situation, the importance of its functions, and the extent and character of its connections, it is not surprising that the nature of its lesions should have been so long misunderstood. As these lesions are seldom fatal, few chances have been afforded of inspecting the eye after death, and, therefore, much that has been written about the pathology of this membrane is based upon conjecture rather than upon the

results of actual observation. Now, however, that the ophthalmoscope has been introduced, the diagnosis of these affections has been made possible. If the instrument did no more than teach us the utterly hopeless nature of certain maladies, and the folly of treating them with harsh, injurious remedies, it would confer incalculable benefit; but, by enabling us to make an early diagnosis in cases hitherto found impossible of recognition, it leads to the establishment of a more rational pathology and more successful practice.

The only affections of the retina which will require notice in a work of this kind are inflammation, amaurosis, and amblyopia.

1. *Acute retinitis* is rare as a pure, uncomplicated disease, but as a secondary affection it is by no means uncommon. There are few cases of violent scleritis, iritis, and corneitis, in which the retina does not participate, to a greater or less extent, during the progress of the morbid action. The causes of the complaint are not always obvious. It is usually said to be owing to exposure of the eye to intense light, as in looking at the sun, or at the fire of a furnace; to excessive and long-continued fatigue of the organ; and to various kinds of external injury, especially such as involve the iris and ciliary ligament. In general, only one eye is affected at the beginning, but as the disease progresses the other may also be invaded, the probability of this being so much the greater if the inflammation is very intense and protracted. Acute retinitis is sometimes observed in lying-in females, within the first ten days after parturition. I have seen several cases of this kind, in each of which the attack seemed to be associated with, or dependent upon, a rheumatic state of the system. Very young subjects rarely suffer from this disease, except as a secondary affection. Finally, the inflammation may invade a part of the retina, or the whole membrane.

The most prominent *symptoms* of acute retinitis are, violent pain, excessive intolerance of light, profuse lachrymation, scintillations, and various kinds of spectres, with rapid failure of sight, generally eventuating in total blindness. The pain, perhaps intermittent at the commencement, soon becomes intense and distracting; it is deep-seated, darts about in different directions, and is often attended with intolerable hemicrania. The patient is annoyed by flashes of light, sparks, or luminous bodies, and by an endless variety of the most grotesque objects, which float before his eyes and disturb his imagination. The affected organ feels full and tense, as if it would burst, and the slightest motion or pressure is attended by an increase of the local distress. Photophobia and lachrymation are usually present in a marked degree, beginning early, and lasting throughout the attack. In the more violent and rapid forms of retinitis there is often total extinguishment of vision in a few hours, before there is any apparent involvement of the other structures of the eye.

The pupil, in acute retinitis, is, at first, slightly contracted, sluggish, and irregular; by and by, however, it becomes dilated, and ultimately, when the disease is fully established, it is expanded to the very utmost, and totally insensible to light. A vascular zone is often perceptible at the anterior part of the sclerotica, but it is much more faint than in iritis and corneitis, and is, therefore, of great diagnostic value. When the malady continues for any length of time, the other tunics of the eye participate in the inflammation; the iris is changed in its color, the cornea is rendered hazy, and the conjunctiva and sclerotica are red and deeply injected. Suppuration of the eye is a rare occurrence.

There is no disease with which acute retinitis can possibly be confounded. The distracting and intolerable pain, the flashes of light, the spectral illusions, the absence of the ordinary phenomena of disease in the other tissues of the eye, the motionless and dilated state of the pupil, and the rapid diminution of sight, with its ultimate complete extinguishment, are unmistakable evidences of the nature of the complaint.

The *prognosis* is most unfavorable. Even in the milder cases, complete recovery is seldom to be looked for, while, in the more violent, total blindness may be considered as inevitable. Under such circumstances, the retina is apparently completely overwhelmed by the disease, its substance being irretrievably disorganized by the inflammatory action.

The *treatment* of acute retinitis must obviously be of the most vigorous character; for, it need hardly be added, after what has been said respecting the rapid and destructive march of the disease, that, even if only a few hours are lost in indecision, the sight may be hopelessly destroyed. Venesection, leeches to the temples, active purgation, and the use of antimonials and opiates, with rapid ptyalism, are the reme-

dies mostly to be relied upon. Unfortunately, the sight is often completely annihilated before the case is seen, the patient, in fancied security, supposing that the inflammation will soon subside of its own accord, when, in fact, it has probably already done its worst.

2. *Chronic retinitis* may be a sequel of an acute attack, or it may exist as an original and independent affection, coming on in a gradual and stealthy manner, slowly, but surely, undermining structure and function. Among the more common causes of the disease are, over-exertion of the eye, long-continued exposure to vivid light, external injury, and neuralgia of the ophthalmic branches of the fifth pair of nerves. Excessive indulgence in eating and drinking, abuse of sexual intercourse, and suppression of habitual discharges, are also capable of producing the affection. A gouty and rheumatic state of the system has been known to predispose to an attack of this kind. Several years ago, a gentleman was under my care on account of chronic retinitis, contracted while travelling in a railway car, during a long journey; he had formerly been a martyr to rheumatism, and had just suffered from a slight attack of his old complaint, when his eye became affected. The symptoms of retinitis had existed, in a gradually gravescent form, for nearly two months, when, almost suddenly, they disappeared upon a recurrence of inflammation in the right knee. One of the most common causes of this disease, according to my experience, is circumorbital neuralgia. In the Southwestern States, chronic retinitis, from this affection, is by no means infrequent. During my residence in Kentucky, I met with many cases which clearly owed their origin to this circumstance alone. The operation for cataract by depression was often followed by chronic retinitis.

The *symptoms* of the disease are generally strikingly characteristic. The patient complains of deep-seated pain in the eye, with neuralgia in the forehead, face, and temple; he is annoyed with sparks, scintillations, or luminous bodies, and his sight progressively diminishes, growing daily more and more dim, so that at length he can, perhaps, barely distinguish light from darkness. In general, he can see objects better in bright than in cloudy weather, and at noonday than in twilight, especially when his back is turned towards the sun. Various fantastic objects usually float before his eye; everything looks as if it were veiled in a mist, haze, or spray; now an insect, as a fly, gnat, or spider, is in the way; now a shower of dust, or particles of dirt; now a thick cloud; now the bough of a tree, a cobweb, a gauze, or an appearance of shooting stars. If, before the sight is much impaired, the patient attempts to read, the letters will be found to look as if they were fused together, turned upside down, or unnaturally short or long; his eyes become immediately fatigued and painful, and, for some hours afterwards, his vision will be proportionately more dim. The pupil, at first merely a little sluggish and somewhat dilated, gradually loses all sensibility to light, and expands to the very utmost, forming merely a black, narrow ring behind the cornea; besides, it is more or less irregular in its shape, the most common deviations being the oval and angular. The interior of the eye looks dead and lustreless, with a greenish or slightly yellowish appearance at the bottom; and the countenance has a peculiarly vacant stare, almost characteristic of the nature of the disease. In the more advanced stages of the complaint, the vessels of the conjunctiva are preternaturally numerous, large, and almost varicose.

A separation of the retina is by no means infrequent. In general, it presents itself as a bluish or grayish bag, of a globular or ovoidal shape, filled with serum, and projecting into the vitreous humor, which is itself always more or less softened and changed in color. This accumulation of serum constitutes what is called *dropsy* of the retina, and may occur in any part of the globe, but in the great majority of cases it will be found at its inferior half, especially when the examination is made after the morbid action is a good deal advanced.

The *prognosis* in chronic retinitis is bad. If the patient is seen early in the attack, a complete cure may occasionally be effected, although such an event is to be regarded rather as the exception than as the rule. In general, the nature of the complaint is entirely overlooked, both by the patient and the practitioner, and the consequence is that the only time when treatment is likely to be of benefit is allowed to pass by in the delusive hope of spontaneous relief. What renders the prognosis worse in this disease is that the morbid action nearly always involves the deeper structures of the eye.

The *treatment* of chronic retinitis must be conducted upon general principles, giving especial consideration to the nature of the exciting cause, the stage of the

complaint, and the condition of the system. There is no question that, until very recently, this disease was usually most sadly mismanaged; for, under the vague name of "amaurosis," by which it was generally known by practitioners, all kinds of remedies, of the most opposite and absurd nature, used to be resorted to, with no other result, commonly, than that of aggravating the local mischief, and inflicting serious injury upon the sight. It was almost the universal custom to bleed, purge, salivate, and starve such patients, often reducing them literally to death's door, by the consequent exhaustion. Such a course was well calculated to ruin both the eye and the system. Now that the mischievous effects of this practice have been fully exposed, there is danger of carrying the error into the opposite extreme, since there is a disposition, at the present day, to cram and stimulate.

Anything like general bleeding and active purgation is only to be thought of in the event of decided plethora and great local congestion. Ordinarily, all the blood that ought to be removed can be advantageously taken by leeches, or the use of a cup to each temple. The bowels should undoubtedly be kept quite free, and the best remedy for the attainment of this end is blue mass, in union with compound extract of colocynth, or a few grains of calomel, rhubarb, and aloes. The diet should be plain and simple, but rather nutritious than otherwise, particularly when there is evidence of debility, when it may also be necessary to exhibit some tonic, as iron and quinine. The great remedy, however, in chronic retinitis, is mercury, given in small doses, twice in the twenty-four hours, for several weeks, or even months, with a view to its general alterative action. The effects of the medicine are carefully watched; for anything even like an approach to salivation must be avoided. The mercury is administered, not only for the purpose of making a direct impression upon the eye, but in the hope also of ameliorating its condition, by improving the general health. Counter-irritation by blister or issue should receive early attention; the feet should be immersed every night for thirty minutes in hot mustard water; the eye should be maintained in a state of the most profound quietude; a green shade should be worn to exclude the light; and gentle exercise should be taken daily in the open air. When there is much pain in the branches of the ophthalmic nerve, a large blister to the forehead often produces a most salutary effect. In such cases, too, strychnia will be useful, either alone, or in union with arsenious acid and aconite, it being understood that these articles are given in very minute doses, and only with a view to their general action.

Any tendency to relapse, which is always very great in this disease, must be counteracted by perfect quietude of the eye for a long time after all morbid action has apparently vanished, and by special attention to the state of the general health. Moderate exercise, a pure air, and the use of the cool or tepid shower-bath, will go far in securing this result. A sea voyage sometimes proves eminently useful.

In addition to acute and chronic retinitis, we may encounter several other forms which are dependent upon constitutional causes. These are albuminous retinitis, met with in many cases of Bright's disease; retinitis, induced by the syphilitic virus; pigmentary retinitis, observed in the children of marriages of consanguinity; and a retinitis attended by hemorrhages into the nervous structure of the eye. These conditions can only be diagnosticated by an ophthalmoscopic examination, and cannot be fittingly described without colored lithographic representations of the lesions.

Embolism of the central artery may be the cause of sudden loss of sight, unaccompanied by any pain: it is recognized by the blanched appearance of the optic disc, and the attenuated condition of the retinal vessels, as revealed by the mirror.

3. *Amaurosis*, a term formerly much employed by ophthalmic writers, literally signifies obscure vision, from whatever cause arising, but, at the present day, it is restricted to dimness of sight, produced by disease of the retina or optic nerve. This lesion may be purely functional, and temporary; or it may be organic, in the worst sense of the word, and, therefore, more or less permanent. Again, amaurosis may be partial, or complete; in the one case, the patient is still able to perceive light, and, perhaps, discern objects with some degree of satisfaction; in the other, he is totally blind, the retina being perfectly insensible to the strongest light, however concentrated. It will thus be seen that the term amaurosis is used simply to denote the existence of a particular symptom, and not the pathology of the disease; a distinction of much practical consequence, and one which, unfortunately, is too often lost sight of by the practitioner.

Amaurosis may arise from numerous causes, many of them of the most opposite

and diversified character. A mere catalogue of these causes would form a large chapter. At one time it is purely inflammatory, at another wholly asthenic; in one case it is induced by plethora, in another by anemia; now it is purely functional, depending upon disease in other parts of the body, now entirely organic or occasioned by the most serious structural lesion. Another circumstance, hardly less interesting in a practical sense, is that amaurosis sometimes comes on in an instant, literally in the twinkling of an eye, as when the organ is suddenly exposed to an intense light. Thus, persons have sometimes been struck blind in gazing at the sun during an eclipse, or in looking at a bird soaring through the air. Microscopists, artists, and other persons whose avocation demands great minuteness of sight, occasionally suffer in a similar manner. A flash of lightning has more than once produced irremediable amaurosis. Worms in the alimentary canal, the repulsion of cutaneous eruptions, the suppression of habitual discharges, derangement of the stomach, congestion of the brain, neuralgia of the fifth pair of nerves, inordinate sexual indulgence, the excessive use of quinine, profuse chewing of tobacco, exhausting courses of mercury, and over-exertion of the eye, may all be enumerated as so many exciting causes of the disease. I recollect a case in which amaurosis was instantly produced by the ferule of an umbrella being thrust into the orbit in such a manner as to compress the ball forcibly against its bony walls. In two other examples, the disease was the result of a slightly contused and lacerated wound of the eyebrow, apparently implicating the supraorbital nerve. Compression of the brain, also, whether produced by effused blood, depressed bone, or some morbid growth, often leads to amaurosis; similar effects occasionally follow concussion of this organ, though they are usually of a transient nature. Cases occur in which amaurosis pursues an intermittent course, the loss of sight recurring once every twenty-four hours, very much like an attack of intermittent fever.

The *symptoms* of amaurosis are such as characterize chronic retinitis, and, therefore, need not be described here. A dilated, motionless, and insensible state of the pupil, a peculiar lustreless expression of the eye, total blindness, and perhaps a congested and enlarged state of the vessels of the conjunctiva, with a singularly vacant stare of the countenance, are signs which can never be mistaken.

It is obviously impossible to lay down any definite rules of *treatment* for a lesion the causes of which are so numerous and diversified as those of amaurosis. The intelligent and conscientious practitioner will not fail to make the disease, in every instance that may come under his observation, an object of special study and inquiry. Cases constantly occur where the causes of the disease are so apparent as to render it impossible to mistake them, and it is to this class that he should especially direct his skill and attention, since experience has shown that many of them are perfectly susceptible of cure. The old, and perhaps not yet entirely exploded, practice of bleeding, purging, and salivating every patient affected with amaurosis, without any proper regard to the nature of the exciting cause, cannot be too severely censured. It affords a melancholy illustration of the folly of prescribing for the name of a disease instead of the disease itself. Undoubtedly plethora should be removed as well as debility, but this can usually be done by milder and more effective means, less likely to ruin the part and system. When the retina is totally disorganized, any treatment, however mild, must be wholly out of the question, except in so far as it may tend to improve the general health, and thus prevent a similar misfortune to the other eye, supposing that one alone is originally affected. One important use of the ophthalmoscope is to throw light upon this class of cases, and to afford information for a more rational plan of treatment.

4. Under the term *amblyopia* may be described an impairment of vision, perhaps slight, or again so serious as to amount to total blindness, unattended with any ophthalmoscopic signs of change of tissue in the early stage.

The causes are such as affect the entire system, as, for example, insufficient supply of blood, the debility consequent upon severe illness or prolonged lactation, the toxic effect of alcohol, lead, and tobacco, and the uremic blood poisoning which attends the latter stages of Bright's disease. Subsequently the optic nerve will generally be found in a state of atrophy.

The treatment must be varied with the cause of the affection, and every effort should be made whilst the insensibility of the retina may be functional to avert the incurable blindness that ensues upon the atrophy of the nerve.

DISEASES OF THE CHOROID.

The only lesion of the choroid requiring special notice is *inflammation*. That this is rare as an independent malady is well known; while as a secondary disease it is probably very frequent, often existing as a complication of iritis, retinitis, and sclerotitis. It is most frequently seen as a result of syphilis, or of traumatic injury, and as a serious complication of high degrees of myopia. It occurs at all periods of life, but is most common in young and middle aged persons, particularly in those whose avocation compels constant and intense application of the eyes to the purposes of minute vision. It has been asserted by Mr. Tyrrell that, soon after the death of the Princess Charlotte of Wales, when the whole English nation went into mourning, an immense number of cases of choroiditis occurred among the dress-makers of the British metropolis, on account of the severe labor imposed upon them by the mercenary conduct of those who had the control of their time and services. Many of these poor creatures, ill-fed, overworked, and deprived of proper air, suffered from disturbance or loss of vision from the disease, brought on by excessive and long-continued concentration of the eyes upon the black material used as the conventional garb of grief. The inflammation, in many of the cases, began in the choroid; in some it took its rise in the iris, retina, or sclerotica; while in a third series of cases it apparently commenced simultaneously in all, or, at least, in several, of these structures. Be this as it may, it is very certain that when the choroid is at all seriously inflamed the other tunics of the eye are extremely liable to become inflamed also; whether the converse of the proposition be true, in an equal degree, the present state of our knowledge hardly permits us to state. Congestion and subacute inflammation of the choroid are probably the cause of the morbid sensibility of the eye so common in young men in college, and in literary persons incessantly devoted to reading and writing. Strumous subjects, and persons enfeebled by ill health, privation, protracted lactation, and loss of blood, are most liable to suffer.

The *symptoms* of acute choroiditis resemble somewhat those of retinitis, only that there is, in general, much less perception of luminous matter. The pain is deep-seated, dull, heavy, and throbbing, shooting about in different directions, especially towards the base of the brain, where it is often exceedingly severe. The eye is tender on pressure; there is a sense of tension or fullness; and every movement of the ball is attended with an aggravation of suffering. There is commonly severe pain, of an intermittent character, around the orbit and in the temple, and the patient is harassed with intense cephalalgia, and a feeling of weight and tightness in the forehead. The sight soon grows dim, and often disappears completely within a few days from the commencement of the attack. Various fantastic objects float before the eye; at first, as small motes or specks, of a grayish, yellowish, or darkish appearance, and afterwards, as the disease augments in violence, as a thick mist, gauze, or veil. The ball of the eye is of a dull reddish, pink, or brick-dust color, and there is generally a faint zone around the cornea, from which the vessels extend backwards over the surface of the sclerotica in fine radiating lines. The conjunctiva itself is seldom much injected. The iris is dull and discolored, and the pupil, contracted and irregular, soon becomes motionless, and adherent to the capsule of the lens, which, together with the lens itself, is frequently rendered opaque, either by plastic deposits, or by disease of their proper substance. Gradually the retina and vitreous humor are assailed, the latter being dissolved and broken down, and the globe, in consequence, converted into a soft, flaccid, fluctuating mass. The sclerotica, also becoming implicated, gives way at some particular point, usually towards the cornea, forming a protrusion, of a bluish color, known by the name of staphyloma.

The *diagnosis* of choroiditis merits special attention. The disease with which it is most liable to be confounded is iritis, from which, however, it may, in general, be distinguished by a careful examination of the eye, and a proper inquiry into the history of the attack. In choroiditis, disturbance of vision is an early and prominent symptom, and always precedes any alteration in the iris; moreover, the loss of brilliancy and the alteration of color of this membrane are always less conspicuous than in the latter disease, and the vascular zone around the cornea is also more faint and dull. In iritis, the sight is often comparatively little affected for some days, although the structure implicated usually undergoes very striking changes within a very short time after the establishment of the disease. Furthermore, in primitive iritis there is always a greater amount of plastic deposit in the anterior chamber,

more irregularity of the pupil, and a more distinctly defined vascular zone around the cornea. When the two maladies have made considerable progress, the symptoms and appearances are generally so much alike as to defy all attempts at accuracy of diagnosis. In such an event, the only guides are the history of the case and a careful ophthalmoscopic inspection.

The *prognosis* of choroiditis is unfavorable. When the disease has made much progress before an opportunity of interposing remedial measures is afforded, the chances are that the sight is already destroyed, or, at all events, so much impaired as to render its restoration impossible. Hence, the importance of an early diagnosis, and of efficient treatment.

The *treatment* of acute choroiditis must, in the main, be conducted upon antiphlogistic principles, with a proper regard, however, in every instance, to the state of the constitution, the violence of the attack, and the age of the patient. A plethoric condition of the system may demand bloodletting, and, with leeching or cupping of the temple, active purgation, and the use of mercury, carried to rapid ptyalism. Reduction of the inflammation must be attempted at all hazards, and in the shortest possible time; a few days, or even twenty-four hours, passed in temporizing, may lead to hopeless blindness. The use of the eye should be entirely prohibited, and the patient confined to a dark room. A solution of atropia should be dropped into the eye several times daily. If the inflammation involve the entire ball, and advance to suppuration, the extirpation of the globe will save the patient much suffering, and probably restore him rapidly to health.

The treatment is, of course, less active when the patient is feeble from previous disease or present suffering, or when the inflammation has already produced serious structural lesion: here our chief reliance is upon local depletion, counter-irritation by blisters to the forehead, temple, or nape of the neck, correction of the secretions, mild aperients, and the gentle operation of mercury, with nutritious food and drink. When the disease has assumed a decidedly chronic form, change of air, sea-bathing, and tonics, particularly iron and quinine, will aid in rebuilding the constitution, and contributing to the maintenance of what little vision may be left.

GLAUCOMA.

The term glaucoma was originally employed to designate a greenish opaque appearance, occasionally seen in the bottom of the eye, and generally dependent upon a change of color of the lens, as yellowish, amber, yellowish-red, or reddish-brown. At present, however, it is used in a mere arbitrary sense, to denote a peculiar form of blindness, attended with various morbid changes of all the structures of this organ.

The disease, which may be either acute or chronic, is obviously of an inflammatory character, as is evinced by the nature of its symptoms, by ophthalmoscopic inspection, and by the results of dissection. In the acute form the humors are opaque and increased in quantity; the retina and choroid are covered with plastic matter, highly vascular, softened, and disintegrated; blood is effused either in a pure state, or intermixed with lymph; capillary apoplexy of the retina is common; the optic disc becomes excavated; and all the tunics of the eye, both internal and external, are profoundly congested, many of the vessels exhibiting a tortuous, varicose appearance. Thus, it is evident that glaucoma, in the sense in which the term is now used, is not an irido-choroiditis, as some have alleged, but essentially an ophthalmitis, involving all the structures of the eye, the humors as well as the tunics. Of its point of departure we are completely ignorant. Uncommon before middle life, it is most frequent from the fiftieth to the sixtieth year, usually affects both eyes, although seldom in an equal degree, at least not at first, and is generally preceded by a prodroma, or state of incubation, the transition from which to the acute stage is sharp and sudden in acute, insensible and gradual in chronic, glaucoma. The subjects of the disease are for the most part presbyopic, weakly, thin, and more or less anemic from previous suffering.

Among the earlier *symptoms* of glaucoma is a gradual impairment of vision, objects appearing more dim than formerly, and looking as if seen through a mist. There is a rapid increase of presbyopia, and the eyes are soon fatigued by any exertion, such as prolonged reading or writing; occasional flashes of light occur, and a halo with prismatic colors is perceived around the flame of a candle. After a while vague

pains are experienced in the eye, brow, and temple, the pupil is enlarged and sluggish, the anterior chamber is diminished, and the eyelids are abnormally tense on pressure.

Acute glaucoma is generally characterized by great violence. The pain, which is often neuralgic, and ocular as well as circumorbital, is either sharp and darting, or dull, heavy, and aching; colored spectra dance before the eye, or flashes of light are perceived; objects appear misty, as if surrounded by smoke; the field of vision is contracted, and total blindness sometimes occurs in a few hours. The subconjunctival tissues are congested and œdematous; the cornea is dull and almost insensible to the touch; the anterior chamber is hazy and abnormally small; the pupil is widely dilated, irregular, oval, and motionless; and the iris, deprived of its fibrous appearance, is of a dirty, grayish, or slaty tint, and pushed forwards by the lens, which is faintly striated, and swollen, as if macerated. The globe, which is almost of a stony hardness, is exquisitely tender, and feels as if it would burst. Sometimes the veins of the iris are so much enlarged as to be visible to the naked eye. Well-marked fever, nausea, loss of sleep, cephalalgia, and great mental depression usually attend the attack. Ophthalmoscopic inspection is impracticable by reason of the opaque condition of the cornea and of the humors.

In chronic glaucoma, which may last for months and even years, the patient being alternately better and worse, the attack generally begins insidiously. The sight gradually grows dim, the eye loses its brilliancy, and dull, aching pain is occasionally felt in and around the orbit. Bright flashes, coruscations, or colored spectra are perceived, at first at long intervals, but afterwards almost constantly, and usually constitute a source of real suffering. The subconjunctival vessels are purple and varicose, and a faint vascular zone is observable upon the sclerotica, in the ciliary region. The cornea, losing its sensibility, is dull and finely granulated or even slightly vesicated; the iris is lustreless and traversed by enlarged veins; the pupil is dilated, irregular, fixed, grayish or grayish green, and occasionally partially adherent to the lens; the humors are cloudy; the anterior chamber is almost obliterated; the eye is uncommonly hard; and vision is either extinct, or reduced to the merest perception of light. The general health is usually considerably impaired, but there is seldom any fever, unless the disease suddenly passes into the acute form. Ophthalmoscopic inspection, possible in nearly all cases, reveals a well-defined and cupped appearance of the optic nerve, with engorgement and pulsation of the retinal veins at the disc.

In the *treatment* of acute glaucoma, ordinary antiphlogistic remedies, however vigorously pushed, are of little, if any, benefit. General bleeding and active mercurialization are not only useless, but positively injurious. Unless prompt relief is afforded, blindness, total and irretrievable, must inevitably result from the rapid changes experienced by the retina from the pressure of inflammatory products, the enlarged and congested condition of the vessels, and the excessive intraocular pressure. Paracentesis of the eye, by taking off some of this pressure, may afford transient amelioration, but complete relief can only be obtained by iridectomy, devised by Von Graefe in 1856, and now almost universally relied upon as the sheet-anchor of our hope in the treatment of this affection. The operation, which consists in the removal of a section of the iris, should be performed early and effectually. Every hour is precious when there is great intensity of action. It affords relief upon the same principle as an incision in external inflammation, by the removal of the excessive tension of the globe, and the drainage of the irido-choroidal and retinal vessels, at the same time that it places the absorbents in a better condition for exerting their peculiar influence upon the inflammatory deposits. Iridectomy should be performed, in acute cases, even if there is complete loss of sensibility of the retina. The sight may not, it is true, be restored by it, perhaps not even materially improved, but the agonizing suffering and inflammation will be sure to be speedily arrested. In chronic glaucoma, where there has been total blindness for some time, no improvement of vision is to be expected, and the operation is performed solely to relieve pain and tension.

The patient, during the performance of iridectomy, should be recumbent, and thoroughly chloroformed. The lids are separated by a wire speculum. The eye, steadied with a pair of forceps, is penetrated with an ordinary cataract knife, or keratome, through the cornea, close to the sclerotica, and immediately in front of the iris, the opening being about one-third of an inch in length. The protruding iris is then grasped with the forceps, drawn out, and cut off to the extent of about

one-sixth of the entire membrane, as far as its periphery. The gap, if made above, will be measurably concealed by the superior lid. Care must be taken not to injure the lens. The after-treatment is conducted upon the same general principles as in the operation for cataract and artificial pupil. The excessive pain and tension rapidly decrease, and a marked abatement also ensues in the inflammation.

STRUMOUS DISEASES.

Strumous ophthalmia exists in various forms and degrees; sometimes as a very mild affection, at other times as a most severe one. It may be acute or chronic, and attack both eyes, or be limited to one. It generally simultaneously involves a number of structures, especially the conjunctiva, cornea, iris, and retina.

Of the exciting *causes* of this disorder very little is known. Its origin is often ascribed to circumstances which have no agency whatever in its production. Sometimes it is directly traceable to external injury, as a blow, or a wound; in many cases it is apparently brought on by long exposure of the eye to a strong light, or by excessive fatigue of the organ, induced by reading, writing, or sewing. Suppression of the cutaneous perspiration is another, if not a frequent, cause of the disease. In young girls, I have occasionally seen it connected with irregularity of the menses, but whether as a cause or an effect could not always be determined. Perhaps the most common cause of all is derangement of the digestive apparatus. Whenever the predisposition exists, as it always does in this affection, almost anything, however trivial, may bring on an attack.

The *age* at which this disease occurs is an important circumstance in its history. It is extremely rare after puberty, and in no instance have I witnessed its outbreak in middle or advanced life. It is essentially a malady of infancy and early childhood. According to my observations, it rarely appears before the age of eighteen months, or two years. It occurs in both sexes, and in every rank and condition of life, but more frequently among the poor, ill-fed, and ill-clothed, than among the refined and wealthy. The offspring of the syphilitic and consumptive, and of those who have suffered from tubercular diseases of the spine, hip, arachnoid membrane, and lymphatic glands, are most liable to it.

The prominent *symptoms* are intolerance of light, excessive lachrymation, and violent pain. The photophobia is usually very distressing. The smallest ray of light is frequently productive of the keenest suffering, and the patient, consequently, uses every possible precaution to prevent its intrusion. For this purpose, he generally, if he is a child, as is commonly the case, creeps into the darkest corner of his chamber, where he covers his eyes with his hands, or buries his head in a pillow, or, perhaps, in his mother's lap. In this condition he often remains for hours, afraid to change his posture, lest the light should meet his eyes, and so increase his distress. Children thus affected frequently experience an aggravation of all their suffering, even from the light of the moon and of the stars, such is the excessive sensibility of the retina.

Lachrymation is commonly a prominent symptom. Exposure to light and cold always increases it. The tears are usually hot and scalding, but their discharge is always attended with temporary relief. Sometimes they are so acrid as to irritate and inflame the cheeks. The quantity of fluid that is thus evacuated in the twenty-four hours may amount to several drachms.

It is rare, in strumous ophthalmia, to witness a copious discharge of mucus, or of muco-purulent fluid. Even when there are excessive photophobia and great lachrymation, there is seldom much secretion of this description; often, indeed, not enough to agglutinate the edges of the lids. In this respect, serofulous inflammation forms a striking contrast with some of the other varieties of ophthalmia, in which an immense quantity of mucus, or of mucus and pus, is discharged during the height of the morbid action, and even during its decline.

There is usually very little redness of the conjunctiva in this variety of ophthalmia. In ordinary inflammation, discoloration of this membrane is a constant occurrence, and is so conspicuous as generally at once to attract attention. In strumous inflammation, the vessels observe a straggling arrangement; they are seldom very turgid, and they extend from the circumference of the ball inwards towards the cornea, where they are often congregated into little groups, or clusters, beautifully interlacing with each other, as in fig. 200. When the disease is violent, or of long

standing, the vessels occasionally pass over the cornea, either singly or in parallel lines, separated by narrow intervals. In ordinary ophthalmia the vessels are extremely numerous, and generally arranged in the form of a confused network. In a word, there are hundreds, where there is one in strumous ophthalmia.

Fig. 200.



Scrofulous Ophthalmia with a Phlyctenula on the Cornea and a Fasciculus of Vessels running into it.

Another important symptom is the existence of minute vesicles at the margin of the cornea, occurring either separately or in groups, and varying in size from the smallest perceptible speck to that of an ordinary pin-head. They each contain a minute quantity of serum, and are frequently encircled by a delicate plexus of vessels. Their shape is globular, ovoidal, or angular. Sometimes they exist partly on the sclerotica and partly on the cornea. As they are witnessed in no other form of ophthalmia, they are of great value as a diagnostic sign.

Strumous ophthalmia seldom continues long without giving rise to opacity of the cornea, presenting itself in different degrees, from the slightest haziness of the part to complete loss of transparency. In the latter case, it is always to be greatly dreaded, as it is generally followed by total blindness and irremediable disfigurement of the eye.

Ulceration of the cornea is another frequent effect of this variety of ophthalmia. It often begins at an early stage of the disease, and may proceed with more or less rapidity until it extends through the entire thickness of the membrane. The most common form of the ulcer is that of a dimple-shaped depression, with smooth and rather sharp edges, the surface looking as if a piece had been scooped out of it. Generally, the ulcer has a hazy appearance, but occasionally it does not differ in its color from that of the adjacent parts, and hence, unless the cornea is examined with great care, while the light is falling upon it at a particular angle, the disease may readily escape detection. Sometimes several such erosions exist upon the eye, forming either simultaneously or in pretty rapid succession. If permitted to progress, they occasionally extend through the different layers of the cornea, as far as the anterior chamber of the eye, the humor of which may, perhaps, escape through the abnormal opening, or, what is more common, the opening is closed up by the membrane of the aqueous humor, or even by the iris itself.

The pain attendant upon strumous ophthalmia is sometimes intense, while at other times it is very insignificant, if not wholly absent. In confirmed cases, it is always aggravated by the slightest exposure of the affected organ to the light, by medicated applications, by disorder of the bowels, by indulgence in eating, by rough contact, and by various other circumstances unnecessary to be mentioned. Occasionally it is situated deeply in the ball of the eye, or in the orbit; sometimes it merely affects the lids and brows; occasionally it is most severe in the temple, forehead, or cheek. It may be sharp, shooting, or darting; dull, heavy, or aching; throbbing, or pulsatile; continued or intermittent. Not unfrequently it assumes a neuralgic character, recurring periodically, like neuralgic pain in other parts of the body. Whatever may be its nature, it is often so severe as to deprive the patient of sleep and appetite, and, indeed, of all comfort, for days and weeks together.

Strumous ophthalmia is rarely attended with any tumefaction of the lids. On the contrary, they usually retain their normal shape and size; in consequence, however, of the excessive intolerance of light, they often present a remarkably drooping appearance, owing to the manner in which they are drawn over the eyes. When the disease is very protracted, the edges of the lids frequently become inverted, so that the cilia impinge constantly against the cornea, thereby inducing opacity of this membrane, great increase of pain, and additional inflammation. Although there is, generally, an absence of swelling of the lids, yet this symptom occasionally exists in a very marked degree, especially in young children of a leucophlegmatic habit, with a thick upper lip, a tumid belly, and a soft, flabby tongue, along with great derangement of the digestive apparatus. The whole system, in such cases, seems to be surcharged with strumous disease, which, in consequence, it is extremely difficult to dislodge from the eyes, which frequently become its victims.

In many cases little vesicles, not larger than the head of a small pin, and filled

with serum, occur on the cheeks, the inferior lids, around the nose, or on the lips. Of a whitish, almost pearly aspect, they are usually discrete, although often closely grouped together, rest upon a slightly reddish base, are most common in children of a deeply-marked strumous habit, and seldom come on until after the inflammation has made considerable progress. Their presence almost invariably denotes great obstinacy in the morbid action, and proportionate difficulty in effecting a prompt and permanent cure.

The *diagnosis* of this affection is usually sufficiently easy. The excessive intolerance of light, the unwonted lachrymation, the absence of redness in the conjunctiva, together with the peculiar straggling arrangement of its vessels, the phlyctenular and opaque condition of the cornea, the want of tumefaction and the manner in which the lids are drawn over the ball of the eye, are signs, which, once observed, can never be mistaken. Add to these phenomena the fact that the disease usually arises insidiously and without any assignable cause, the strumous appearance of the features, the coldness of the extremities, the tumid condition of the belly, the formation of vesicles on the face, and various other evidences of the strumous diathesis, and all doubt respecting the true nature of the case must instantly vanish.

The *prognosis* must necessarily be influenced by various circumstances, as, for example, the progress and extent of the morbid action, the state of the patient's health, and the nature of our remedies. In the milder forms, in the earlier stages of the malady, and under proper management, recovery of the affected organ may generally be reasonably predicted. But, under opposite circumstances, the worst consequences may, not unfrequently, be looked for. Ulceration of the cornea often extends, despite our remedies, to a great depth, and sometimes even to complete perforation; an event which is sure to be followed by permanent impairment, if not total loss, of sight. Superficial opacity, even when it is diffused over the greater portion of the cornea, is generally readily amenable to treatment, but when it involves several of the layers of the membrane, or when a considerable period has elapsed since its formation, the case will necessarily be unpromising, both as it respects the future appearance of the eye and the amount of vision.

Treatment.—The great remedy in the treatment of this disease is quinine, either alone, or conjoined with other means. I am very certain, from long experience, that it deserves to be placed at the head of all the articles used in this variety of scrofulous affections. To produce its full effects, however, it must be administered with due regard to the patient's system. Injudiciously given, it may not only prove useless, but positively hurtful. There are, according to my experience, two distinct classes of strumous disease of the eye. In the one, the patient is pale and thin, with a languid circulation, and cold extremities; in the other, he is stout and robust, the cutaneous circulation being active, and the hands and feet habitually warm. Other points of dissimilarity readily suggest themselves, but these it is unnecessary to point out, as the distinction must be sufficiently apparent. Now, to treat such cases alike would be a palpable absurdity. It is only by properly discriminating between them that we can expect to arrive at a satisfactory result, as it respects the employment of this important therapeutic agent. Hence, one practitioner will often mismanage a case, which another, having more judgment and more experience, will promptly cure, the disease, perhaps, disappearing as if by magic.

The use of quinine, in both forms of the complaint, should usually be preceded by the exhibition of a moderately brisk cathartic of calomel and rhubarb, to clear out the bowels and correct the secretions. When there is an acid condition of the alimentary canal, I generally combine with the cathartic a few grains of bicarbonate of soda. Thus, a most effectual beginning is made in the treatment of the disease. If the case comes under the first division, that is, if the patient is pale, thin, and habitually cold, I begin at once with the use of quinine, commonly in combination with sulphate of iron, tartar emetic, and opium, in quantities proportionate to the age and strength of the individual. For a child, for example, of ten years, a grain and a half of quinine, one grain of iron, the twelfth of a grain of antimony, and the fourth of a grain of opium, carefully mixed, will be a suitable dose, repeated every eight hours, or, if the symptoms are urgent, even every six hours. If pills or powders are offensive to the patient, the articles may be given in solution, laudanum or morphia being substituted for the opium. When there is a highly-marked strumous diathesis, the iodide of iron may sometimes be used instead of the sulphate, but in most instances I give the latter the preference. Tartar emetic I rarely omit in any case, as it is a most valua-

ble remedy in the treatment of scrofulous disease, both of the eye and of other parts of the body. It is a powerful controller of capillary action, and at the same time a most potent sorbefacient, rendering it thus particularly applicable when the malady is attended with a deposit of plastic matter. The opium allays pain and intolerance of light, and prevents the antimony from irritating the stomach and bowels. The quinine and iron, whether in the form of sulphate or iodide, are powerful tonics; they improve and invigorate the digestive organs, increase the fibrin and coloring matter of the blood, equalize the circulation, augment the temperature of the extremities, and powerfully aid in correcting the strumous diathesis. By means of these remedies, assisted by a proper diet and due attention to the bowels and secretions, almost any case of scrofulous ophthalmia may, in the class of patients under consideration, be effectually relieved in a comparatively short period.

When the skin is dry and inactive, a tepid bath may occasionally be used, or, what is better, the body may be sponged once a day with tepid salt water, followed by frictions with a coarse, dry towel. Flannel should be worn next the surface, both in summer and winter; and the greatest attention should be paid to the preservation of the temperature of the feet. When they are habitually cold, they should be plunged twice a day, for a few minutes at a time, into cold water, and then rubbed with a dry cloth. Dover's powder, in this condition of the system, in doses of two or three grains, thrice in the twenty-four hours, is often highly beneficial, in promoting perspiration and soothing the system.

In the second class of cases, where the general health is apparently but little impaired, where the countenance is florid instead of being pallid, and where the extremities are, for the most part, warm, the quinine is most advantageously conjoined with sulphate of magnesia, tartar emetic, and morphia, in the form of the saline and antimonial mixture.

When the inflammation is very severe, the quinine may be omitted until the disease has assumed a subacute character, and in that event, also, I occasionally take blood freely from the arm, or by leeches from the anterior part of the temples, within an inch of the outer commissure of the lids. In the strong and robust, iron, in every form, is totally inadmissible. The diet, too, must be more restricted, and there is a greater necessity for more active purgation. Indeed, the treatment should be strictly antiphlogistic, as much so as in inflammation of the eye from ordinary causes.

As to counter-irritation, collyria, and salves, so much used in this complaint, they cannot, as a general rule, be too pointedly condemned. Except in the later stages of the complaint, in some rare circumstances, it is difficult to conceive of any case in which they would be likely to be beneficial. Indeed, I know of no class of remedies which do more mischief, or which are so well calculated to fret and annoy the patient, and to support and perpetuate the morbid action. Setons are abominably filthy and painful, and should be discarded from this branch of surgery; tartar emetic ointment and croton oil cause injurious irritation; in short, the only eligible article of this class of remedies is a small blister behind the ear, or, what is preferable, because more easily managed and more permanent, a very small issue, in this situation, made with the Vienna paste. This, when the eschar is detached, may be dressed, twice a day, with a little adhesive plaster, and will furnish a free discharge for several weeks, when, if necessary, it may easily be reopened by the application of a little more paste, or some irritating ointment.

The best collyrium, undoubtedly, is a solution of nitrate of silver; but, to answer the purpose, it should be very weak, and not be used until the inflammatory action is greatly diminished, when it may assist in expediting and perfecting the cure, by contracting the enlarged vessels of the conjunctiva and cornea, by allaying the morbid sensibility of the eye, and by promoting the absorption of effused lymph. The strength, at first, should rarely exceed half a grain to the ounce of water, which may be gradually increased to a grain, or even twice, thrice, or four times that quantity, according to the circumstances of the case. Sulphate of zinc, acetate of lead, Goulard's extract, and similar articles are generally worse than useless.

When there are ulcers on the cornea, and they do not yield to the remedies already enumerated, they should be touched, as lightly as possible, once every other day, with the point of a camel-hair pencil wet with a solution of nitrate of silver, in the proportion of about three grains to the ounce of water; or, still more cautiously, with the nitrate of silver in substance. The former, however, is generally preferable, unless the ulcer is in a phagedenic or gangrenous condition, when the latter should

take the place of the solution, as being more prompt and efficacious in its action. The salts of lead should never be used, as dense opacities may result from insoluble deposits upon the cornea.

The only salve which I ever employ in this affection is the ointment of the nitrate of mercury, in a very dilute state; generally in the proportion of about five grains to the drachm of prepared lard. The ointment of the shops is entirely too strong, and cannot be used without the risk of materially augmenting the morbid action. Thoroughly diluted it may be advantageously employed in cases attended with great relaxation of the vessels of the affected part, opacity of the cornea, and adhesion of the lids. The proper way to use it is to anoint, every night at bedtime, the edge of the lower lid with a small pencil, dipped in the salve, a portion not larger than half a grain of rice sufficing at each application.

Some patients experience great relief from bathing the forehead, face, and temples frequently with warm water, strongly impregnated with common salt; while others derive most benefit from bathing with cool, cold, or hot water. Atropia affords relief to the photophobia, and should be used in solution. The eyes must always be well protected with a green shade, but green glasses and goggles should be carefully avoided. Such a practice, indeed, cannot be too much deprecated. The same remark is applicable to compresses and bandages. I have seen numerous cases in which irreparable mischief was done by the protracted use of these articles. The true practice consists in protecting the affected organs in such a manner that, while they are sufficiently screened from the light to render the patient comfortable, they shall have the full benefit of cool air. As the disease declines, more and more light should gradually be admitted, until at length they receive their accustomed supply, since light is the natural stimulus of the eye, and must, therefore, not be withheld too long, otherwise the organ may be rendered morbidly sensitive.

I have rarely derived any essential benefit, in the treatment of any form of scrofulous ophthalmia, from iodide of potassium, so much vaunted by some practitioners. Formerly I was in the habit of prescribing this article quite frequently, but it so often totally disappointed my expectations that I have, of late years, laid it entirely aside. In obstinate cases, benefit is obtained, especially in weakly children, requiring an alterant and tonic, from the exhibition of bichloride of mercury, in very minute doses, as the twentieth or twenty-fifth of a grain, in union with aromatic tincture of bark. I am well aware that the salt in this prescription undergoes some chemical change; but this renders it, perhaps, only the more efficacious. It is neither necessary nor proper to carry the remedy to the extent of ptyalism to obtain its full effects. Indeed, such an occurrence should always be carefully avoided. Cod-liver oil is frequently of great benefit, especially in the more feeble classes of cases, and should be given in such doses as the stomach will bear without nausea. When the debility is very unusual, the child should be permitted the free use of milk punch and the lighter kinds of meat.

When there is hemicrania, or excessive circumorbital pain, anodynes are necessary, particularly at night, to allay suffering and procure sleep. Under such circumstances, some practitioners are in the habit of applying belladonna ointment to the affected parts, and in some cases I have found the remedy of service, although, in general, it has disappointed me.

During the later stages of the affection, the patient should take gentle exercise daily in the open air, to improve his general health, and to invigorate his constitution. As an excellent means of preventing relapse, a moderate use of the remedies above mentioned should be persisted in for a considerable length of time after all disease has apparently vanished.

NEURALGIA OF THE EYE.

This affection is very common in this country, especially in the Southwestern States, and may depend for its origin either upon local or constitutional causes. In the former case, it arises most generally from disease of the eye, brain, or neighboring parts, in consequence of local congestion, if not actual inflammation, provoked by external injury, the lodgment of a foreign body, the presence of a decayed tooth, the pressure of some tumor, or excessive fatigue of the eye; in the latter, it is usually developed under the influence of miasm, disorder of the digestive apparatus, exhaustion of the nervous system, or the derangement of some important secretion.

A species of neuralgia of this organ not unfrequently occurs during the progress of rheumatism, gout, and tertiary syphilis.

Neuralgia of the eye may exist as a primary affection, commencing in the organ itself, or it may be secondary, being caused by an extension of disease from the adjacent structures, especially the ophthalmic branches of the fifth pair of nerves. The latter form, according to my observation, is by far the more common of the two. The affection is most frequent in persons of a nervous, irritable temperament, and often occurs in association with neuralgia of other parts of the body. No age is exempt from it.

Of the pathology of this disorder our information is very indefinite. While in some cases it is unquestionably of an inflammatory character, as is evinced both by the nature of the exciting cause and the peculiar features of the symptoms, in others it appears to be dependent solely upon irritation of the ophthalmic branches of the fifth pair of nerves, or upon reflex action, the consequence of derangement of the liver, stomach, bowels, kidneys, or teeth.

The disease is frequently, if, indeed, not commonly, ushered in by marked derangement of the general health, as dyspepsia, headache, constipation, flatulence, or acidity of the stomach, even when the attack depends upon a strictly local cause. The pain, which serves as its distinctive feature, is at first slight and transient, being of a sharp, lancinating character, dull, heavy, and aching, or like an electric shock, darting about in different directions, and recurring, perhaps, several times during the day and night. The eye is morbidly sensitive, and intolerant of exposure and exertion. By and by, the suffering becomes more fixed and severe; it is deeper seated and more diffused, the lids and conjunctiva often exhibit a tumid and reddish appearance, the circumorbital pain and tenderness are great, and there is always, particularly during the height of the attack, profuse lachrymation, the tears being hot and scalding. In the more violent attacks, the forehead, temple, and upper part of the face are involved, the eyebrows are knit, the lids are spasmodically contracted, and the slightest ray of light is a source of intense agony. The pain, which is nearly always most severe at one spot, generally comes on gradually, increasing steadily until it reaches a certain point of intensity, when it slowly, if not suddenly, abates, or perhaps altogether disappears. In the miasmatic variety of neuralgia, the paroxysm, in its mode of invasion, closely resembles that of intermittent fever, the suffering recurring regularly once a day, or every other day, lasting a few hours, and then going off entirely, leaving, perhaps, merely a slight degree of tenderness in the eye, orbit, temple, and forehead.

The constitutional symptoms vary. In general, they are very mild, even when the local suffering is unusually violent, being limited to some derangement of the digestive apparatus, along with more or less headache, want of appetite, and a sense of lassitude and despondency. Anything like marked fever rarely exists. It is only when the affection is very protracted, as when it depends upon organic disease of the eye, or of the ophthalmic branches of the fifth pair of nerves, that the general health is apt to become permanently impaired.

Neuralgia of the eye, or of the eye and neighboring parts, is easily distinguished by the situation and peculiarity of the pain and the history of the case. The principal affections with which it is liable to be confounded are rheumatism, gout, and tertiary syphilis.

The prognosis is usually favorable, provided the affection receives early and proper attention, otherwise it will be very liable to induce permanent blindness, whether it is originally seated in the eye or in the circumorbital region. It is, of course, unamenable to treatment when it is caused by organic disease of the brain or optic nerve.

In the *treatment*, a primary object should be the prompt detection and removal of the exciting cause. When this has been effected, the disease generally yields to the most simple measures. Gastro-enteric disorder is rectified by emetics, mercury, antacids, and other suitable remedies; the foreign body is extracted; the decayed and worrying tooth is lifted from its socket. The miasmatic form of the malady is usually speedily relieved by quinine, in doses of five to ten grains twice or thrice a day, either alone or in union with strychnia and arsenious acid. If the patient is bilious, as indicated by nausea, want of appetite, and aching of the back and limbs, the administration of the salt is preceded by an active emetic, or emetico-cathartic, to remove vitiated matter, and aid in restoring the secretions. Purging must not

be neglected, and the diet must be properly regulated. When the affection is very obstinate, the most suitable general remedy is a combination of quinine, belladonna, strychnia, and arsenious acid, given in moderate doses, perseveringly continued for a number of successive weeks, with an occasional intermission of a few days.

The rheumatic form of the disease is best met with colchicum and morphia; the syphilitic, with mercury and iodide of potassium. Sometimes a change of air will effect a cure when everything else apparently fails.

During the violence of the attack, relief is sought by the exhibition of morphia and diaphoretics, sinapisms to the forehead and temple, and the immersion of the feet in hot water.

The most reliable local remedies, in a soothing as well as curative point of view, are leeches, especially when there is marked congestion or actual inflammation; vesication with ammonia or cantharidal collodion; friction with Granville's lotion, aconite liniment, or veratria ointment; the hypodermic injection of morphia; the application of electricity; and the use of anodyne plasters, as the opium, belladonna, or stramonium. In some cases the moxa, so highly extolled by Larrey in the treatment of this affection, will be found useful, the cauterization being made over the eyebrow, along the course of the supraorbital nerve. Excision of this nerve has occasionally been practised, but rarely with any beneficial effect.

PYOPHTHALMITIS.

This most destructive form of inflammation of the eye, originally described as phlebotic ophthalmitis, but which, under the improved system of nomenclature, is more appropriately designated by the term pyophthalmitis, occurs under a variety of circumstances, and, as the name implies, owes its origin to thrombosis of the veins, or to the same causes as pyemia. It is most frequently observed in lying-in females, in connection with puerperal fever, in erysipelas, in typhoid fever, and after severe injuries and surgical operations, especially those involving the veins of the extremities.

Occurring always as a secondary affection, its attack is generally, if not invariably, coincident with symptoms of pyemia, or a slow form of fever, preceded by rigors, and accompanied by excessive nervous depression, delirium, pains in the back and limbs, swelling of the joints, great restlessness, gastric irritability, and dryness of the mouth and tongue, the latter of which is covered with a brownish coat. The eye becomes involved at a period varying, on an average, from the fourth to the tenth day, the first evidences of disease being deep-seated and excessive pains, redness and tumefaction of the conjunctiva, swelling of the lids, contraction and immobility of the pupil, and a hazy appearance of the cornea which soon runs into complete opacity. Pus is rapidly effused into the chambers of the organ, as well as among its coats, which finally slough and collapse.

The only affections with which pyophthalmitis is liable to be confounded are gonorrhoeal and purulent inflammation; but from these it can always readily be distinguished by the history of the case, independently of any other consideration.

It must be obvious that a disease which runs its course with such frightful rapidity, and which is characterized from its inception by such excessive violence, can be but little influenced by treatment, however judiciously or vigorously prosecuted. The most reliable means are leeching and free division of the chemosed conjunctiva, with medicated lotions to the lids, temples, face, and forehead; active purgation; the use of the antimonial and saline mixture; and puncture of the cornea to relieve the eye from intraocular pressure. General bleeding is seldom admissible, but anodynes should be freely employed.

OSCILLATION OF THE EYE.

This affection, consisting, as the name implies, in an almost perpetual rotatory motion of the eye round its antero-posterior axis, is occasioned by a want of harmony in the action of the oblique and straight muscles. It may be produced by a great variety of causes, some of them operating directly upon the eye, others indirectly through the brain. Of the former are congenital cataract, and albinism, or a want of black pigment, and inflammation of the choroid, retina, and iris, with or without disorganization of the vitreous humor; of the latter, apoplexy, cerebral

tumors, and serous effusions, attended with permanent compression of the ophthalmic nerves. Morbid growths in the orbit may exert a similar influence. However induced, it is usually aggravated by excessive fatigue of the eye, and by whatever has a tendency to disorder the general health.

The motion of the eye in this affection varies in degree, in different cases and under different circumstances, from the slightest aberration from the normal standard to the most disagreeable deformity. In general, it is rotatory, but now and then from side to side; the patient is entirely unconscious of it, and cannot control it, although it ceases during sleep. Vision, except in rare instances, is more or less defective, the eye is easily fatigued, and a sense of weariness is often complained of upon the slightest exertion. Shortsightedness is a common phenomenon. The prognosis is nearly always unfavorable.

The treatment is altogether empirical. Even after the removal of the exciting cause, a cure can seldom be effected, it being apparently quite impossible, in almost any case, to overcome the antagonizing action of the affected muscles. In congenital cataract the oscillation continues, in a greater or less degree, no matter how early an operation may be performed for the relief of the disease. When the motion depends upon paralysis of the muscles of the eye, or disorder of the brain, the treatment must be conducted upon general principles, and so also when it is caused by the pressure of an intraorbital tumor.

IMMOBILITY OF THE EYE.

Immobility of the eye, technically termed *luscitas*, may be induced by a variety of causes, of which the most prominent are external injury, inflammation of the orbital tissues, orbital tumors, and paralysis of the ocular muscles, the result of lesion of the ophthalmic nerves, or disease of the brain and its membranes. The immobility may be complete, the patient having lost all control over the organ, or he may still be able to incline it in a certain direction, although, perhaps, with great difficulty. The affection is sometimes congenital, and is then always irremediable, especially when it is dependent upon hydrocephalus, defective organization of the brain, or the presence of some morbid growth in this organ.

In the treatment of *luscitas*, the first object should be to ascertain the nature of the exciting cause; when this cannot be removed, no hope can, of course, be indulged in regard to a cure.

MALIGNANT DISEASES OF THE EYE.

The only two forms of malignant diseases of the eye are encephaloid and melanosis. The variety of soft carcinoma, known as fungus hematodes, is by no means infrequent, but as it generally occurs in combination with encephaloid, and forms, in fact, merely a species of it, it is not entitled to separate consideration. Of scirrhous, properly so termed, I have never seen an instance in this organ, and it is questionable whether there is a perfectly reliable case of it on record, notwithstanding all that has been said respecting it.

1. *Encephaloid*.—Encephaloid of the eye, which includes the glioma and glious sarcoma of German pathologists, although their structure differs very greatly, generally occurs in children from the second to the tenth year; I have, however, seen it several times within less than six months after birth; and cases are occasionally met with rather late in life. The oldest patient in whom I have observed it was forty-two years of age. Of the influence of sex and temperament in the production of the disease in this organ, nothing is known.

The malady always begins in the depths of the eye, generally in the retina, from which, as it proceeds, it gradually extends to the other structures, until, at length, they are involved in one confused and disorganized mass. The earliest symptom is generally a yellowish, amber, golden, or buff-colored spot, far back in the organ, which, upon inspection, is found to look very much like the eye of a cat. This spot rapidly increases in volume, but finally entirely disappears, being replaced by dark matter; the pupil, at first sluggish, becomes permanently dilated and insensible to light; the lens is thrust forwards against the iris; and the anterior chamber is completely obliterated. These appearances are well illustrated in fig. 201.

As the malady progresses, the eye, enlarged in every direction, presents a distorted

appearance; and, the cornea at length giving way, a fungous, cauliflower-looking mass is formed, which, projecting beyond the lids, soon becomes the seat of a copious, sanious, fetid discharge, and a source of frequent and abundant hemorrhage. The patient now experiences a great deal of pain, the lymphatic glands in front of the ear take on disease, and the constitution exhibits all the evidences of the carcinomatous

Fig. 201.



Encephaloid, in its Earlier Stages.

Fig. 202.



Encephaloid, after Ulceration.

cachexia. Finally, hectic fever sets in, the body is rapidly emaciated, and death soon follows, from the joint effects of irritation and hemorrhage, the period which intervenes between its occurrence and the commencement of the malady varying, on an average, from six to nine months. The annexed drawing, fig. 202, from a clinical case, exhibits the appearances presented after ulceration has occurred.

There is no disease with which it is possible to confound encephaloid; glaucoma and amaurosis bear, it is true, some resemblance to it in its earlier stages, but any doubt upon the subject may usually be dispelled by a thorough inspection of the interior of the eye with the aid of the ophthalmoscope, which will always reveal the existence of a tumor in the one case, and the entire absence of it in the other. Besides, glaucoma and amaurosis are extremely rare in infancy, especially as simple and independent affections; hence, the very fact of there being serious disease deep in the interior of the eye is calculated to awaken suspicion as to its malignant character. After the morbid growth has made some progress, its features are generally too well marked to admit of mistake. The absence of black pigment will always distinguish encephaloid from melanosis.

The entire mass is generally very soft and spongy, especially in the more advanced stages of the disease, and is largely composed of vascular material. In 1857, I removed from a child, two years of age, an encephaloid eye, in which these characteristics existed throughout in a marked degree. The tumor, which had commenced nearly twelve months previously, projected slightly beyond the lids, and involved all the structures of the orbit, excepting the bony fabric. The lachrymal gland was greatly indurated, as well as considerably enlarged; and the crystalline lens, of a yellowish color, and more than twice its natural size, had undergone the earthy degeneration.

Encephaloid is always fatal; if removed, however early, it is sure to recur, or show itself elsewhere; if left to itself, it gradually involves the different structures of the orbit, and even extends along the optic nerve to the base of the brain and its membranes. The eyelids generally escape, although they are always much enlarged, discolored, and infiltrated with serum.

2. *Melanosis*.—Melanosis of the eye, fig. 203, including its sarcomatous and carcinomatous varieties, is much less common than encephaloid, with which it occasionally coexists. It is generally associated with melanosis in other parts of the body, and is rarely met with before the age of thirty-five or forty. Its starting point is usually in the choroid. Be this as it may, the first evidence of melanosis of the eye is the presence of a dark, black, or purple mass deep in the vitreous body, apparently in contact with the retina, and entirely devoid of the yellow, metallic lustre so conspicuous in the other malignant disease. The pupil is indolent in its movements, vision is

materially impaired, and the eye loses its natural expression. As the morbid growth extends, it gradually disorganizes the humors of the eye, thrusts forward the iris, obliterates the anterior chamber, and causes ulceration of the cornea, or of the cornea and the sclerotica, with a consequent fungous protrusion, from which

Fig. 203.



Melanosis of the Eye.

Fig. 204.



Melanosis of the Eyeball.

there is always a dark, fetid, and abundant discharge, with occasional slight hemorrhage. In the latter stages of the malady, the ball of the eye is generally more or less lobulated, and of a characteristic black color, not uniformly but at different points of its extent, the dark hue strikingly contrasting with the white appearance of the sclerotica. The tumor, which sometimes equals the volume of an orange, generally projects a considerable distance beyond the level of the lids. The appearances of this disease are well seen in fig. 204; the iris has been partially detached, and the mass is making its way through the sclerotica, near the cornea.

Although the progress of melanosis is generally considerably slower than that of encephaloid, its termination is not the less certainly fatal. The average duration of the disease is from nine to eighteen months. Sometimes a case occurs which lasts several years. There is seldom much pain until ulceration sets in, when the suffering rapidly increases, and sadly tells upon the constitution. Lymphatic involvement, also, now takes place; the disease gradually extends to the structures of the orbit; and death finally occurs from exhaustion, very much as in encephaloid, which it likewise resembles in its disposition to relapse after extirpation.

The only remedy for encephaloid and melanosis is extirpation, which, if done at all, should be done early and most thoroughly. If deferred until ulceration has begun, speedy relapse will be inevitable. During my pupilage, I saw Professor George McClellan remove this organ in three instances for these affections, and in each there was a reproduction of the malady in less than a month. The patients were children under nine years of age, in two of whom the symptoms were such as to hold out strong inducements for the operation. I have myself extirpated the eye in nine cases, in seven for encephaloid, and in two for melanosis, and in every one, so far as I have been able to judge, mischief was done and the fatal crisis hastened. In one instance I performed not less than three operations in almost as many weeks, first removing the ball and then portions of the lids and neighboring parts, but without any ulterior benefit, death occurring a few months from the time of the first excision. In 1844, I saw a lad, thirteen years of age, upon whom the late Professor Mussey had already operated twice, with the result of a speedy relapse in each instance. When the case fell into my hands, some weeks after the last operation, the morbid growth had advanced so far as utterly to preclude the propriety of further interference.

EXTIRPATION OF THE EYE.

Extirpation of the eyeball alone, known as the operation of enucleation, is necessary when, either from disease or traumatic injury, it is placing the sound eye in danger of loss of vision from sympathetic ophthalmia; it may also be proper in the incipient stage of malignant disease, as then the removal of the entire globe affords the only chance of successful treatment.

The patient is placed recumbent, under the influence of chloroform. The lids

being separated by a speculum, the conjunctiva is incised immediately behind the cornea, in its entire circumference. The tendon of each muscle is divided at its attachment to the globe by scissors, after having been brought into view with a strabismus hook. Finally, the optic nerve is divided by a pair of blunt-pointed, curved scissors, and the entire globe may be then removed. The operation is followed by little hemorrhage, and is comparatively free from danger. A light water-dressing, with attention to cleanliness, will suffice to prepare the cavity for an artificial eye, which may be introduced in a fortnight.

Extirpation of the globe and the contents of the orbit is sometimes required on account of malignant disease of the eye. The operation is sufficiently easy of execution, but, as it is liable to be attended by copious hemorrhage, it should not be undertaken without proper precaution. The patient being under the influence of chloroform, and the head firmly secured upon a low pillow, an incision, which need not exceed three-quarters of an inch in length, is made from the outer canthus towards the temple, with a view of facilitating the remaining steps of the operation. The tumor being transfixed by a double hook, or by a double ligature, the knife, a narrow and rather sharp-pointed bistoury, is passed circularly around it, dividing the conjunctiva, and thus separating the morbid mass from the lids. The excision is completed by including all the soft structures of the orbit—muscles, cellulo-adipose matter, and lachrymal gland—sometimes, indeed, even the periosteum itself, and the nerve as far back as possible. The deep dissection will be much facilitated by the use of the scissors and a pair of slender dressing-forceps. The blood, which often flows in torrents, is wiped away with a sponge mop, and, when the operation is over, the cavity is stuffed with lint wet with a saturated solution of subsulphate of iron, a thin compress moistened with sweet oil being placed upon the lids and gently supported by a bandage. This effectually prevents further hemorrhage. The incision in the outer canthus is closed by suture. Clearance of the orbit is not attempted until the establishment of suppuration.

Extirpation of the eye, performed early in life before the body has attained its full growth, is nearly always followed by a partial arrest of development of the orbit. The lids usually experience a similar fate.

ARTIFICIAL EYE.

When an eye has been partially destroyed, the defect may often be admirably remedied by an artificial substitute; but, before this can be done to advantage, the stump of the original organ must be placed in a healthy condition, otherwise much annoyance, if not positive suffering, may ensue. For this purpose it will generally be necessary to subject the patient to a mild antiphlogistic course, and to the use of astringent collyria, in order to relieve morbid action, and induce contraction of the dilated vessels. Thickened conjunctiva, bands and bridles, inverted lashes, and, in short, whatever interferes with accurate adaptation, must receive preliminary attention. I have rectified a squinting stump by the division of the internal straight muscle, and in several instances I have been compelled to excise considerable portions of the lower lid before the patient could comfortably wear the false eye.

The best stump for an artificial eye is one which has sustained very little loss, and which, consequently, is just a little below the natural size. A collapsed ball does not afford adequate support, and the case is still worse when the eye has been extirpated. It is very important, also, that the stump should retain its muscular power, otherwise it will be impossible for it to move in concert with the sound organ. The morbid sensibility and pain so frequently experienced in wearing an artificial eye are generally dependent upon the cornea, and it is, therefore, a good rule, whenever the surgeon has his choice, to remove the whole of this membrane as a preliminary measure. A want of attention to this point might seriously endanger the safety of the sound eye.

An artificial eye, fig. 205, is merely a thin, light shell of enamel, highly polished, almost hemispherical in shape, and accurately corresponding in size and color to the sound organ. Establishments for its manufacture exist both in this country and in Europe. To obtain a good fit, the patient should apply in person, or, if this be impracticable, send a proper model, accompanied with a drawing of the color and appearance of the healthy eye.

Fig. 205.



The insertion of a false eye is readily effected after it has been dipped in cold water by passing it, with the broad end out, under the upper lid, and then holding it there with the forefinger of one hand, while the lower lid is forcibly depressed with the other until the edge of the shell sinks into the inferior palpebral sulcus. Removal is accomplished by an opposite procedure, that is, by drawing down the lower lid, and insinuating a hook, a large pin, or a piece of wire, beneath the lower edge of the disc, which, lest it fall and break, should be received into the hand or dropped upon some soft substance.

As cleanliness is of the greatest importance, the eye should be taken out every night at bedtime, and well washed, the stump and lids thoroughly bathed, and any undue irritation that may arise promptly combated by suitable collyria and aperients. At first the eye should not be worn longer than a few hours each day, but as the parts become accustomed to its presence the interval may gradually be increased. In about a year a new one will probably be required, the old being rendered useless by the corrosive action of the humors of the diseased organ.

DISEASES AND INJURIES OF THE LACHRYMAL APPARATUS.

The lachrymal organs consist of the lachrymal gland, canals, and sac, together with the nasal duct, which are all liable to inflammation and its effects, and also to some of the heterologous formations, either as primary or secondary affections.

a. *Lachrymal Gland.*—The principal affections of this little body are inflammation, cystic tumors, and chronic enlargement.

1. Inflammation of the lachrymal gland, technically called *dacryadenitis*, is most common in young subjects of a strumous diathesis, as an effect of cold or external injury. In disease of the globe and orbit the gland is sometimes involved secondarily, and this, in fact, appears to be the way in which it usually suffers, idiopathic disease being exceedingly infrequent. There are no signs by which the affection can be discriminated from other maladies in its immediate vicinity, although its presence may always be suspected when there is pain, more or less severe, in the situation of the gland, accompanied with swelling and tenderness on pressure. Confirmatory evidence is afforded by the absence of lachrymal secretion, or the existence of inordinate dryness of the conjunctiva, œdema, pain, and tension of the upper lid, and displacement of the ball of the eye, which is generally pushed somewhat downwards and inwards by the pressure of the enlarged gland, as well as embarrassed in its movements. The conjunctiva always participates in the inflammation, becoming red and painful; the periosteum of the orbit is also liable to be involved, and the bone itself may be attacked. Fever and headache are among the more common symptoms, and in many cases the patient is delirious.

Dacryadenitis may terminate in abscess, or pass into the chronic form, the gland remaining enlarged and tender for many months. The formation of matter is usually indicated by the occurrence of delirium, or an increase of it if it previously existed, a disposition to rigors, and an aggravation of the circumorbital inflammation.

The *treatment* is rigidly antiphlogistic; by general bleeding if there is much suffering conjoined with plethora; by leeches to the outer part of the upper lid, forehead and temple; by active purgation; by the antimonial and saline mixture; and by the application of medicated dressings, either in the form of light poultices or fomentations. If suppuration occur, the matter is evacuated by an early incision through the upper part of the conjunctiva, beneath the corresponding lid. The chronic form of the disease is combated by milder means; principally by purgatives, occasional leeching, and tonics. Now and then the puncture made for the relief of the abscess is disposed to remain fistulous, and must then be lightly touched, from time to time, with nitrate of silver or the end of a fine probe, dipped in a weak solution of acid nitrate of mercury.

2. A *cystic tumor* occasionally forms in the lachrymal gland, in consequence, apparently, of the obstruction of one of the lachrymal ducts, and the retention of lachrymal fluid. The contents of the cyst are of a whitish color, of a thin, watery consistence, and of a saline taste; sometimes they are thick and viscid, like synovia. The tumor varies in volume from that of a pea to that of an almond, is irregular in shape, bears a very close resemblance, in its appearance, to a small bladder, is composed of a single layer, is always unilocular, and chiefly occurs in young subjects, under thirty years of age. The diagnosis is necessarily obscure, if not altogether

uncertain. When the tumor approaches the surface, and is elastic to the touch, an exploring needle, carefully inserted, may assist in determining its nature; but, in general, this can be done only by an incision, large enough to expose it. The eyeball is usually displaced forwards and inwards, but as this protrusion may be caused by other affections, such, for instance, as morbid growths of the orbit, entirely unconnected with this gland, it is evident that a useful hint only can be deduced from that circumstance.

The *treatment* is the same as in cystic formations in other parts of the body. The safest remedy is an injection of a very weak solution of iodine, or the introduction of a little mercurial ointment, to excite adhesive inflammation. Extirpation of the sac should only be attempted when the tumor is large and indisposed to yield to other and milder means.

3. The lachrymal gland is liable to *chronic enlargement*, attended with induration and other textural changes, producing a state of things which has occasionally been confounded with true scirrhus, a disease which rarely occurs in this organ. What countenances this opinion is, first, that the enlargement and induration often take place in young subjects, long before the period for the appearance of scirrhus in other situations; and, secondly, that dissection, however carefully conducted, always fails to disclose the characteristic structure of this heterologous product. Nevertheless, I do not feel inclined altogether to deny the possibility of the occurrence of scirrhus, much less of encephaloid, in this gland; for it is unquestionable that, in not a few of the reported cases, the enlargement of this organ was carried to a most extraordinary extent; far, indeed, beyond what might be supposed to have happened had the disease been of a benign nature. Moreover, it is certain that the gland is liable to be affected secondarily by carcinoma, as is seen in encephaloid of the globe of the eye, and in epithelioma of the lids and orbit. The surgeon must, therefore, often be in doubt respecting the actual nature of these tumors, which is, probably, for the most part, adenoid, sarcomatous, or cysto-sarcomatous. Hence, it will be well to extirpate them without delay, whenever they are at all of a suspicious character, or whenever they are not amenable to the ordinary discutient means.

4. *Extirpation* of this body is accomplished by making an incision through the outer commissure of the lids, and raising the upper flap from the corresponding portion of the ball; a procedure altogether preferable to cutting through the substance of the lid, as generally advised. The enlarged gland being thus exposed is carefully liberated with the finger or handle of the scalpel, and lifted from its bed along with any other suspicious-looking structure. The cutaneous wound is approximated by suture, and supported by a light compress, confined by a suitable bandage.

β. *Lachrymal Canals*.—These little passages, which convey the lachrymal secretion to the tear-bag, are liable to laceration, inflammation, obstruction, and stricture.

Laceration of the lachrymal tubes, one of the effects incident to injury in this region, is usually caused by a blow, or by a fracture of the nasal and maxillary bones. Walton mentions an instance in which it was produced by a slight scratch on the inner corner of the eye in a scuffle. It is characterized by a puffy, emphysematous swelling, crackling under the finger, and gradually spreading over the cheeks and eyelids, which are sometimes completely closed. The symptoms generally disappear spontaneously in a few days.

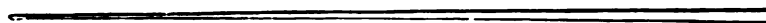
Inflammation of these passages, whether primary, or propagated from the neighboring structures, is attended with thickening of the lining membrane, more or less uneasiness, muco-purulent discharge and watering of the eye, the tears being unable to reach their natural destination. The subjects of the disease are generally persons of a strumous predisposition, who are very prone to take cold, and to suffer from other ophthalmic affections, especially chronic conjunctivitis. The proper remedies are attention to the general health, which is often much impaired, and gentle, but steady, purgation, with a leech occasionally to the inner canthus, and the use of slightly astringent injections.

Obstructions of the lachrymal canals may be produced in different ways, as chronic thickening of their lining membrane, direct adhesion of their walls, or deposit of lymph in the submucous cellular tissue. It may also be caused by the presence of an earthy concretion, a detached and intercepted eyelash, or inspissated mucus. A wound of these passages is a serious accident, inasmuch as it is very liable to be followed by loss of function. The closure, however induced, may be partial or complete, temporary or permanent: in some cases it affects merely the orifices of the

tubes. The characteristic symptom is epiphora, but the nature and situation of the obstruction can only be determined by an examination with the probe.

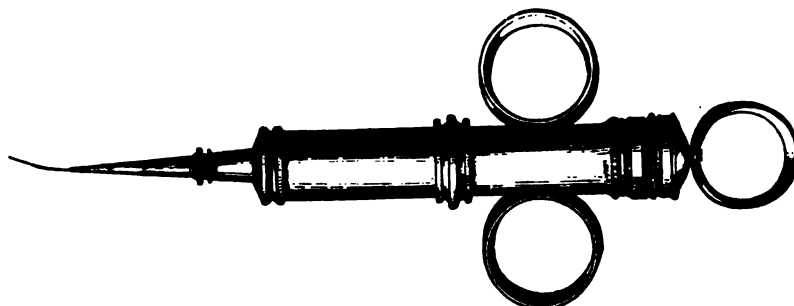
When the obstruction is extensive, or dependent upon firm adhesions, or the presence of organized lymph, no benefit will be likely to result from treatment; under opposite circumstances, relief should be attempted by gradual dilatation, and mildly astringent injections, the proper instruments for performing these operations being Anel's probe and syringe, depicted in figs. 206 and 207. Great tact and caution are

Fig. 206.



Anel's Probe.

Fig. 207.



Anel's Syringe.

necessary in the use of these instruments, otherwise they will be sure to increase the disease instead of diminishing it. The probe should not, at first, be introduced oftener than once every fourth or fifth day, and the operation should never be commenced without some preliminary treatment, with a view of rendering the parts more tolerant of manipulation. The eye should always be well bathed for some time after the passage of the instrument, and, if considerable irritation arise, a brisk purgative must be given, and a leech applied to the inner canthus. The dilatation may generally be greatly promoted by the daily use of some astringent injection, composed, for example, of the eighth of a grain of nitrate of silver to the ounce of water, or a weak solution of zinc, alum, or lead. Without, however, some constitutional treatment, local measures will generally afford very little benefit; and even then, under the most favorable circumstances, much time and patience will be required to effect a permanent cure.

Foreign bodies in the lachrymal canal must be extracted with the forceps, or forceps and knife. The intruded eyelash is sometimes seized with difficulty, owing to the fact that it is almost completely buried in the passage.

In consequence of accident or disease, the orifice of the inferior lachrymal canal is occasionally displaced, being turned forwards or upwards, away from the ball of the eye, so as to allow the tears to flow over the edge of the lid. When this is the case, relief may be afforded by a very simple operation, suggested by Mr. Bowman, consisting in the complete division of the canal by means of a very delicate knife, carried from below upwards over a grooved director. During the after-treatment care must be taken to prevent the edges of the incision from growing together, by the occasional use of a probe. The object of this procedure is to extend the orifice of the duct backwards to the point where the tears naturally accumulate.

When the orifice of this canal is obliterated, the canal itself remaining pervious, an incision should be made just below the seat of the obstruction, across the tube, which should then be slit up on a probe.

γ. *Lachrymal Sac*.—The tear-bag is liable to laceration, inflammation, both acute and chronic, abscess, and fistule.

1. *Laceration* of the lachrymal sac usually occurs as a complication of fracture of the nasal and maxillary bones. In a case related by Dr. Taylor it was occasioned by blowing the nose. However induced, it is liable to be followed by excessive swelling of the parts, with a tendency to emphysema, the formation of abscesses,

and obliteration of the sac from inflammatory deposits. To prevent these untoward effects, the treatment should be prompt and vigorous, our main reliance being upon leeches and cold water-dressing, with active purgation.

2. Inflammation of the lachrymal sac, the *dacryocystitis* of ophthalmologists, commonly occurs in strumous and syphilitic subjects, either from exposure to cold, disease of the neighboring structures, or, as is more generally the case, from obstructions of the nasal canal, the inferior outlet of the sac. The sac, under these circumstances, is placed in the same condition as the urinary bladder in stricture of the urethra, or chronic enlargement of the prostate gland. In either event there is retention of the natural contents of the reservoir, which, undergoing chemical decomposition, become thereby a source of inflammation, suppuration, and even ulceration. I imagine that most of the more simple cases of *dacryocystitis* are induced in this way. The disease may occur at any period of life, but is uncommon in infancy and childhood.

The acute form of the malady is characterized by unusual violence, the symptoms, both local and constitutional, being generally much more severe than the size and importance of the affected part would seem to justify. The reason, however, is sufficiently apparent when we reflect upon the organization of the sac, and the nature of the structures immediately around it. The disease begins in the form of a hard, circumscribed swelling, immediately below the tendon of the orbicular muscle, which, gradually increasing in bulk, soon becomes the seat of the most exquisite pain, deep-seated, throbbing, and extending in different directions; the skin has a red, erysipelatous blush, and slightly pits on pressure; the eyelids, cheek, and nose are deeply involved in the morbid action; the lachrymal canals no longer perform their office; there is high fever, with agonizing headache; and the patient is often violently delirious. If the excitement is not arrested, as it rarely will be when it has attained this height, suppuration will set in, thus greatly augmenting the suffering.

The treatment of acute *dacryocystitis* is rigidly antiphlogistic. Leeching, and even venesection, may be necessary; purgatives and antimonials are freely used, along with anodynes, to allay pain and promote sleep; and the parts, painted several times a day with dilute tincture of iodine, are kept constantly wet with a strong solution of acetate of lead and opium. A small blister applied to the swelling is occasionally of great service.

3. The formation of *abscess* of the lachrymal sac is denoted by the pointed character of the swelling, by the erysipelatous blush of the skin, by the throbbing nature of the pain, and by the sense of fluctuation, which is always present when the matter has made some progress towards the surface. In that event, too, there is often a small vesicle of the epidermis with an attenuated state of the skin, showing where the abscess, if left to itself, will ultimately open.

The treatment is to afford free vent to the pent-up fluid, and the earlier the operation is performed the better, both for the part and system. The tendon of the orbicular muscle, made tense, serves as a guide to the knife, which is carried perpendicularly down over the most prominent part of the swelling. A very small tent is inserted to insure patency of the wound.

The inflammation having subsided, the artificial opening may close, although, generally, it will remain, especially if there is any obstruction in the nasal canal, or disease of the lachrymal bone, as may happen when the affection is of a strumous or syphilitic origin. In such a case, the bone may be so completely necrosed as to require removal. When the sac continues open, or breaks at intervals, it discharges more or less pus, or puriform mucus, constituting what has been called *mucocoele*. Under such circumstances, the cure may be promoted by astringent injections, or simply by washing out the sac several times a day with tepid water and soap, or common table tea.

4. *Chronic dacryocystitis* is often a troublesome and obstinate disease. It may be a sequel of the acute form, or it may exist as an original lesion, coming on gradually and stealthily, without any evident cause, and unaccompanied by any marked symptoms. It is most common in strumous persons, in consequence of attacks of measles, scarlatina, and smallpox, and frequently lasts for months and years, producing thickening of the lining membrane, and obstruction of the lachrymal and nasal ducts. Sometimes it is dependent upon disease of the pituitary membrane, caries of the bones of the nose, or the presence of a nasal polyp.

The disease is recognized by a small tumor at the side of the nose just below the

tendon of the orbicular muscle, and by a constant feeling of uneasiness of the part; there is generally some inflammation of the conjunctiva and lids, and occasionally, although not always, some discoloration of the skin in the situation of the sac. The swelling is caused by the retention of the tears and the accumulation of the mucous secretion, which thus serve to keep up the morbid action. By pressing the tumor gently with the finger, its contents discharge themselves through the lachrymal canal, and partly, also, through the nasal duct; a method usually adopted by the patient to obtain temporary relief, being often performed three or four times a day. Epiphora, or watering of the eye, is generally another of the annoyances experienced by persons laboring under this affection.

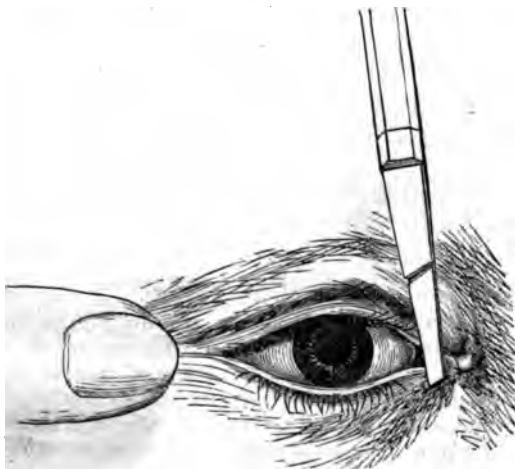
Chronic dacryocystitis is treated upon the same principles as the acute form of the disease, only that the remedies must be plied less vigorously. Attention to the general health is indispensable; the secretions, which are often much at fault, must early be corrected; the diet must be properly regulated; and the bowels must be kept under the influence of mild purgatives, containing a small quantity of blue mass or calomel. Locally, the best application is a leech, renewed every six or eight days, use being made, in the interval, of the dilute tincture of iodine, painted upon the skin over the sac once every twenty-four hours. Benefit, of a very important character, will also accrue from the daily use of mildly astringent injections, thrown into the sac along the lower lachrymal canal with an Anel's syringe. We cannot be too cautious, however, in the use of these means; for, should they be too irritating, the morbid action will be increased instead of being diminished. The practitioner has a great variety of articles from which to select, and he has only to be careful that he properly graduates their strength to the tolerance of the parts. When the disease is dependent, as it often is, upon partial obstruction of the nasal duct, an attempt should be made to effect clearance with the probe, used upon the same principle as in the corresponding affection of the lachrymal canals. For this purpose, the short probes described by Dr. Hays may be employed; or those introduced by Mr. Bowman, consisting of six sizes, which are to be preceded, in their employment, by his operation of slitting up the inferior canal from its orifice to the lachrymal sac, upon a small grooved director, or incising it with a pair of fine scissors.

The introduction of the probe necessarily involves a very thorough acquaintance with the anatomy of the lachrymal passages. The operation is usually performed upon the inferior canal, while the patient is seated upon a chair with his head resting against the breast of the surgeon. The lower lid being made slightly tense by placing a finger over the outer commissure, the probe is inserted from above downwards, and gradually brought to a horizontal position, until the point reaches the farther side of the sac; the instrument, being now raised against the superciliary arch, is passed steadily downwards, with a slight inclination backwards, along the nasal canal, into the inferior chamber of the nose, care being taken to execute the whole

proceeding in the gentlest possible manner. The operation is repeated at first twice a week, then every other day, and finally every twenty-four hours, until all necessity for its employment ceases.

If this plan should fail, and an abscess be threatened, the sac should be laid open, and a style worn in the nasal duct. The patient being seated upon a chair, with his head supported upon the breast of an assistant, the surgeon, standing behind him, stretches the tendon of the orbicular muscle by placing his finger over the outer commissure, and, taking the tendon as his guide, he plunges a narrow, sharp-pointed bistoury, held almost horizontally, into the sac, and then finishes the operation by bringing the instrument into the vertical position, and

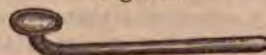
Fig. 208.



Operation for Relieving the Nasal Duct.

cutting from within outwards. The annexed cut, fig. 208, exhibits the manner in which the operation is usually done. A style made of silver, from ten to twelve lines long, and represented in fig. 209, is immediately conveyed into the nasal duct, its head protruding at the orifice of the wound, where, if there is any danger of its falling into the sac, it may easily be secured by a thread, passed through an aperture in the instrument, and fastened to the side of the nose with a bit of court-plaster.

Fig. 209.



Style for the Nasal Duct.

The style is occasionally withdrawn and cleansed. Instead of this instrument, the surgeon may use a piece of catgut or unoled sole leather, or, what is preferable, a bougie of slippery elm, which, while it is easy of introduction, has the effect of rapid expansion, thus greatly expediting the dilatation.

When the duct is firmly closed, it may be necessary, as a preliminary to the insertion of the style or bougie, to effect clearance with a common pocket probe. If the obstruction is irremovable, the proper plan is to drill a suitable opening—a pretty large one—into the lower portion of the lachrymal bone, to allow the tears and mucus to pass into the upper chamber of the nose.

When the obstruction is overcome, some surgeons, instead of using a style, insert a silver tube, left permanently in the passage. This practice, however, is highly objectionable, as the instrument is liable not only to create irritation in the passage, but, from the action of the tears, mucus, and pus, to become eroded and decomposed. Many years ago I met with an instance in which such an instrument had escaped from the nasal duct, and perforated the upper jaw.

5. *Fistule* of the lachrymal sac is nearly always the result of abscess, dependent upon closure, partial or complete, of the nasal duct. Disease of the lachrymal and turbinated bones, or of the pituitary membrane, and various morbid growths of the nose, as polyps and exostoses, may also give rise to it. A congenital lachrymal fistule is occasionally met with.

The external opening is usually situated just below the tendon of the orbicular muscle, as in fig. 210, and is subject to temporary closure. The discharge is either muco-purulent, or mucous, being of a yellowish or whitish appearance, and of a thick, ropy consistence; the parts around are generally somewhat tender and inflamed, and the tears often flow over the cheeks, in consequence of the congested condition of the lachrymal passages.

Fig. 210.



Lachrymal Fistule in its Chronic Stage.

As the cause of this affection is obstruction of the nasal duct, it is evident that the only remedy is its removal. This is to be accomplished in the manner already pointed out under the head of chronic inflammation. When the patency of the nasal duct has been reestablished, the fistule will usually close spontaneously in a few days; should it be slow in healing, the cicatrization may be promoted by the application of nitrate of silver, or a weak solution of acid nitrate of mercury. I have occasionally seen the orifice close promptly, after the failure of other means, under the use of a small blister.

6. Having already spoken of the principal diseases of the nasal duct, and the means of overcoming them, in connection with inflammation and fistule, it is not necessary to enter into any formal disquisition of them here. This is the less called for, because they are of infrequent occurrence, most obscure in their diagnosis, and, in great degree, beyond the reach of remedies.

INJURIES AND DISEASES OF THE LIDS.

The lids are subject to various affections, some of which are peculiar to them, others common to them and other parts of the body. The most important of these affections are wounds, boils, tumors, malpositions, paralysis, and inflammation.

1. *Wounds* of the lids should be treated on general principles. A clean cut should be united by suture, with wire in preference to thread, introduced in such a manner as not to interfere with the mucous membrane, or the tarsal cartilage. Pins are quite out of the question, and plaster alone should never be trusted to on account of the great mobility of the parts. The nicest adaptation of the divided surfaces is to be

aimed at, as any malapproximation is liable to be followed by trichiasis, entropion, or ectropion.

When a lid is severed from its connections, torn through at the centre, or divided at the commissure, the edges should be well trimmed, and then united by suture, aided by adhesive strips. Occasionally a compress and bandage will be required; but, in general, the globe of the eye will afford sufficient support to the affected parts. When the lachrymal orifice is involved in the laceration, the greatest care should be exercised to prevent its closure.

Wounds of the eyebrows demand the same attention as similar lesions of the lids, both in regard to accuracy of adaptation and retentive measures.

A disfiguring cicatrice of these parts may often be advantageously dissected out and exchanged for a more seemly one; but such a procedure usually requires proper preparation of the system, lest, erysipelas arising, the beauty of the result be thus marred.

2. A *congenital fissure* sometimes occurs in the eyelids, especially in the upper; it may exist by itself, or in union with harelip, or with harelip and cleft of the iris, as in a case observed by Heyfelder. The defect is rectified by an operation similar to that for harelip, apposition being maintained by the finest suture and isinglass plaster.

3. *Emphysema* of the lids may arise from external injury, from disease, or from blowing the nose violently. A case of this occurrence, from a gunshot wound of the frontal sinus, is related by Baudens. In the majority of instances, the air gains admission from the nasal cavity, in consequence of ulceration or rupture of the Schneiderian membrane. The characteristic symptoms are, a tumid condition of the affected lids, and a peculiar crackling sensation perceived on pressing them with the finger. The affection generally rapidly disappears under the application of cold water and a dose of nperient medicine. When the distension is very great, a few punctures may be made into the skin.

4. A *stye* is a small, inflammatory swelling at the edge of the lid, of a furuncular nature, attended with pain, heat, and itching, with a tendency to suppuration. It is, in fact, nothing but a boil, modified by the structure of the parts in which it is developed. The disease probably has its origin in one of the bulbs of the cilia, and is most frequently met with in persons of a strumous constitution, laboring under derangement of the digestive apparatus. I have seen it much oftener in females than in males, particularly in young girls who take but little exercise, and are subject to irregularity of the menses. Some individuals are peculiarly prone to this disease, suffering almost habitually for months together, one stye appearing after another, or each having a disposition to assume a chronic course. The upper lid is more frequently affected than the lower.

The proper practice is to encourage the suppurative process with warm fomentations, or a light poultice, and to puncture the swelling as soon as matter has fairly begun to form. If the stye is very painful, a leech may be applied to its surface, and a brisk cathartic directed. When the affection becomes chronic, or has a tendency to frequent recurrence, special attention must be paid to the correction of functional derangement, by the use of purgatives, alterants, tonics, and a judicious regulation of the diet. The best local remedies are a weak solution of iodine, and slight scarification, to relieve vascular engorgement.

5. Various kinds of *tumors*—horny, warty, sebaceous, encysted, serous, hairy, benign and malignant—form upon the lids, in their substance, or along their free edges; but, as they do not differ from similar growths in other regions, it is not necessary to enter into any elaborate account of their nature and treatment. Most of them are easily recognized and treated, the proper remedy being excision, performed as soon as the morbid growth acts hinderingly or disfiguringly. Those seated along the edge of the lid may usually be snipped off with the scissors, or, if the patient dreads pain, they may be removed with the ligature, any tendency to reproduction being afterwards repressed with nitrate of silver. When the tumor occupies the substance of the lid, a horizontal incision, embracing the skin and fibres of the orbicular muscle, is made across it, when it may be seized with the tenaculum, and either dissected or dug out, as may be most convenient, care being taken, if it is encysted, not to leave any of the sac behind, nor, in any case, to injure the palpebral cartilage. The edges of the wound are approximated by the interrupted suture, which is the only dressing required.

One of the most common tumors in the upper lid—it does not occur in the lower—is the *fatty*, which often attains the size of a currant, in the course of two or three months, and is productive of more or less impediment of motion, as well as of some degree of soreness. It is almost always associated with derangement of the digestive organs, occurs at various periods of life, sometimes even in young children, and generally originates in the cellular tissue between the orbicular muscle and the palpebral cartilage. It is usually somewhat globular in shape, hard to the touch, and unaccompanied with discoloration of the skin. Its pressure sometimes causes partial absorption of the cartilage. Laid open, it is found to consist of a soft, fatty substance, frequently intermixed with a few drops of pus, and contained in an imperfect cyst. The term fatty tumor is the most appropriate one for it. The proper remedy is excision; it never recurs, but similar growths are liable to form in its vicinity. Attention to the constitution is generally necessary to counteract this tendency.

A *fibrous tumor* is not unfrequently met with in the lids, especially in the lower; it is usually solitary, of a rounded or ovoidal shape, of a dense consistence, and of an imperfectly fibrous structure. Situated between the orbicular muscle and the fibro-cartilage, its tendency is to perforate this substance, and, as it increases, to extend towards the inner surface of the lid, where it often presents itself as a soft, fungous, vascular excrescence. Such a growth is seen in fig. 211. The proper remedy is excision, performed by carrying the knife horizontally across the lid. No local applications are of any avail.

Wart-like *excrescences*, of a florid color, and of a soft, fleshy consistence, are sometimes seen upon the inner surface of the lids; they are generally small, and, when attached by a narrow pedicle, occasionally exhibit an appearance similar to that of a nasal polyp. Removal is readily effected with the scissors, repullulation being prevented by means of sulphate of copper.

Carcinoma of the eyelids, generally in the form of epithelioma, fig. 212, occasionally presents itself, either as an original affection or as a secondary involvement. In the former case, it usually begins as a fissure, a shot-like tubercle, or a warty excrescence, either at the free border of the lids or in their cutaneous structure, and gradually involves their entire thickness, thus producing a foul, painful, and intractable ulcer. Care must be taken not to confound the disease with syphilis. Its slow progress, the puckered condition of the affected parts, and the slight swelling which attends it will generally be sufficient to establish the diagnosis. Elderly persons are most subject to it; and it is more common in the lower lid than in the upper. The treatment is the same as in carcinoma in other situations.

Several cases—probably four or five—have been recorded, in which the lower lid was the seat of a small tumor, containing a *cellular cysticerce*, fig. 213. The patients were nearly all children, the subjects of slight injury, as a blow or contusion. Such a tumor cannot, of course, be diagnosed previously to its removal.

6. *Syphilis* of the eyelids may occur from direct inoculation, or as an effect of a constitutional taint. In either event, the disease usually attacks the edge of the lids, in the form of an irregular ulcer, with hard, everted edges, and a foul, unhealthy bottom, with little discharge. Sometimes the disease breaks out upon the surface of the lids, from which it gradually extends until it causes complete perforation. Considerable pain and swelling with œdema of the conjunctiva generally attend its progress; and

Fig. 211.



Fibroid Tumor of the Lower Lid.

Fig. 212.



Epithelioma of the Lower Lid.

Fig. 213.



Cysticerce of the Lower Lid.

these phenomena, together with its great obstinacy, always serve to distinguish it from carcinoma. Not unfrequently, evidence of syphilis exists in other parts of the body.

Syphilis of the lids is sometimes congenital, evidences of its effects showing themselves within a few weeks after birth. The infant is always puny, and covered with scales, scabs, pustules, and copper-colored blotches, either alone or in association with excoriations about the anus, nose, lips, and ears.

The treatment is by mercury and iodide of potassium, assisted by the topical application of nitrate of silver and of the dilute ointment of acid nitrate of mercury.

7. Inversion of the lids, as seen in fig. 214, the *entropion* of ophthalmologists, is generally the result of severe and protracted inflammation of the eye, attended with

Fig. 214.



Entropion of both Lids.

excessive intolerance of light, compelling the patient to make constant and powerful efforts to exclude it from the retina. The consequence is that the lids are drawn with great firmness over the ball, not several times during the day, but incessantly, thus inducing relaxation of the skin and orbicular muscle, and, also, as a necessary result, inversion of the cilia. Granular and strumous diseases of the eye are, according to my observation, the most common causes of entropion: cases occasionally occur where it is produced by very slight inflammation, especially if, as not unfrequently happens, the individual has naturally a very redundant lid, or a

sort of hypertrophous condition of its cutaneous and muscular tissues.

Entropion sometimes affects all the lids, either simultaneously or successively, as I have witnessed in a considerable number of cases; more commonly, however, it is limited to one or two. In degree it varies from the slightest change in the natural position of the organ to the complete curling up of its inner edge, the cilia being perfectly concealed from view. In the advanced stage of the affection, the skin of the lid is thrown into numerous horizontal folds, the fibres of the orbicular muscle are stretched and relaxed, the tarsal cartilage is rendered concave in its vertical diameter, and the lashes are stiff and straggling.

The injurious effects which entropion exerts upon the eye may readily be imagined. The lashes, constantly pressed against the anterior part of the ball, fret and irritate the conjunctiva and cornea, keeping up inflammation, with muco-purulent discharge, profuse lachrymation, and intolerance of light. The mischief is particularly apparent in the cornea, which, in consequence of the friction of the lid, soon becomes the seat of plastic deposits, interfering with the transmission of light, and often eventuating in total blindness.

Although various remedies have been suggested for the cure of this disease, the only one at all worthy of reliance is the excision of an elliptical portion of integument, extending from one extremity of the lid to the other, and embracing a few of the fibres of the orbicular muscles. Much judgment is required in order accurately to proportion the amount of substance to be removed, the great danger generally being that the operator takes away too little, thus favoring speedy relapse. Particular

Fig. 215.



Entropion Forceps.

instruments, as that, for example, sketched in fig. 215, have been devised for pinching up the skin and giving the flap a proper shape; but the scientific surgeon needs no such aid, a pair of dissecting forceps and scissors being quite sufficient for his purpose. Excision having been effected, the edges of the wound are neatly tacked

together by three or four points of suture, to be removed at the end of the third day. Very little, if any, after-treatment will be required. If all the lids are inverted they may be operated upon at one sitting, as I have done in numerous instances.

8. *Ectropion*, exhibited in fig. 216, the reverse of the above condition, may be caused by long-continued inflammation, attended with excessive thickening of the conjunctiva, as in granular lid; but in the great majority of cases it is produced by the contraction of vicious cicatrices, especially by such as are the result of scalds, burns, and escharotic applications. Loschge, Schiette, and others have witnessed ectropion as a congenital malformation.

The eversion presents itself in various degrees, being sometimes very slight, and at other times so great as to turn the lid completely inside out, hanging off from the eye like a shutter. However this may be, it is always accompanied by an inflamed, thickened, and indurated condition of the palpebral conjunctiva, and generally also by more or less disease of the eye, owing to the constant exposure of the ball to light and dust. In cases of long standing the ocular conjunctiva is dry and hypertrophied, and the cornea often exhibits opaque specks, obstructing vision. The affection is most common in the lower lid, and, in its worst forms, is often attended with a remarkable elongation of the part in its horizontal diameter, so that the lid is not only everted but turned away considerably from the ball.

Slight ectropion, depending upon inflammation, may sometimes be relieved solely by antiphlogistic means, which, by promoting the contraction of the enfeebled and relaxed structures, gradually restore the lid to its pristine position. The removal of the thickened and indurated palpebral conjunctiva, in the form of an elliptical fold, sometimes greatly facilitates the cure. When the affection has been caused by a vicious cicatrice, an extensive dissection may be necessary to effect the object, and even then success is by no means always certain, owing to the remarkable reproductive tendency of the inodular tissue. I have, however, repeatedly effected excellent cures by this procedure, in apparently the most unpromising cases. The operation consists in dissecting up the lid freely from its unnatural attachments, placing a well-oiled compress upon the raw surface, and making the part heal by granulation, elevation of lid being assisted by adhesive plaster, or by a thread passed through its edge, and secured to the forehead or cheek, according to the site of operation. If the lid is very large and ill-shaped, it may be necessary to cut out a triangular flap, fig. 217, and a very good cure is sometimes effected, in the more common cases of ectropion, simply by this means.

Fig. 216.



Ectropion of the lower Eyelid.

Fig. 217.



Operation for Ectropion.

Fig. 218.



Plastic Operation on the Eyelid.

When the parts are much disfigured, or partially lost, whether by accident or disease, we may attempt the formation of a new lid, although we cannot flatter ourselves that our efforts will often succeed, especially if serious injury has been sustained by the tarsal cartilage, as in that event it will hardly be possible to obtain a good support for the new organ. The flap may be borrowed from the cheek or

temple, or partly from the one and partly from the other. The preceding cut, fig. 218, affords a good idea of the nature of the operation.

9. The lids are sometimes attached by morbid *adhesions* to the ball of the eye, thus not only impeding its movements, but occasioning serious deformity. The most common causes of the occurrence are scalds and burns, and the contact of escharotic substances, as nitric acid and quicklime. The defect is sometimes congenital, although this must be extremely rare, as I have never seen an instance. Relief is attempted by the cautious use of the knife, the contiguous surfaces being afterwards kept apart by soft lint, and by the daily destruction of the new adhesions with the probe. The cure will necessarily be tedious, and require the exercise of a great deal of patience.

Dr. Hays recently published the particulars of several cases in which, after a thorough separation of the parts, he succeeded in effecting a good cure by the interposition of a thin silver plate, or a piece of thin tin-foil, shaped somewhat like an artificial eye, the lids being kept in close contact with the ball by means of strips of isinglass plaster. The foreign body is removed daily, the parts being well syringed before it is reinserted. The cicatrization is usually completed in from three to four weeks.

10. Inversion of the eyelashes, technically called *trichiasis*, represented in fig. 219, may exist as an independent affection, or as a complication of entropion. Gene-

Fig. 219.



Trichiasis.

erally caused by chronic disease of the lids, especially psoriasis and eczema, it sometimes comes on without any assignable cause, and at a period of life so early as almost to induce the belief that it may occasionally be congenital. In some persons the cilia are naturally very short, stiff and straggling, and the slightest inversion of the edges of the lids may produce a very severe trichiasis. The lashes are generally bent in different ways, some towards the eye, some outwards, and some in the direction of the length of the lids. The constant rubbing of the faulty cilia against the ball keeps up serious disease, and often leads to opacity of the cornea, not unfrequently followed by total blindness.

Trichiasis, dependent upon entropion, generally disappears the moment the lid is put in a condition to resume its proper position.

When the cilia alone are inverted, the only feasible remedy is excision of the part of the lid in which they are implanted, care being taken not to injure the palpebral cartilage; the little wound soon heals, and no deformity ensues. When all the cilia are turned in, the procedure which I usually adopt is to include them in two horizontal incisions, extending the whole length of the lid, from one end to the other. Nothing short of this ever answers the purpose, nor will this suffice, unless every bulb is taken away with its corresponding hair. Save the unseemly appearance caused by the absence of the lashes, it is astonishing what little disfigurement such an operation occasions.

It has been proposed to cure this affection by inoculating the bulbs of the faulty cilia with dry tartar emetic, with a view of causing their destruction by the resulting inflammation. I must confess I have an aversion to such a procedure. Evulsion, or drawing out the cilia by their roots with a pair of forceps, is equally objectionable; first, because the process is one of difficulty, and, secondly, because it rarely succeeds.

11. The *edges* of the lids are liable to a troublesome eruptive disease, the characteristic symptom of which is a distressing itching; it is evidently a species of herpes, or eczema, seated in the orifices of the Meibomian glands, and is generally known by the name of tarsal tetter. The affection is almost peculiar to young subjects, of a strumous predisposition, with light hair, eyes, and complexion. When it becomes chronic, as it is wont to do, it is a source of much annoyance, if not positive suffering, keeping the parts constantly sore, itchy, watery, and irritable. Persons thus affected are often unable to read or sew for months and years together. The disease is aggravated by exposure to the light, the use of stimulating food, loss

of sleep, and, in short, whatever has a tendency to disturb the secretions or damage the general health.

It is characterized by a reddish appearance of the edges of the lids, by more or less itching, and by the presence of bran-like scales at the roots of the cilia, accompanied by an inspissated, glutinous secretion of the Meibomian follicles, lachrymation, epiphora, injection of the conjunctiva, and intolerance of light. In the milder forms of the disease, some of these symptoms are either wanting, or they exist only in a slight degree, or they are altogether absent at one time and present at another. In chronic cases, the edges of the lids, losing their angular shape, are gradually rounded off, and assume a rough, villous, or granular appearance; the mucous membrane is abnormally thickened, the orifices of the lachrymal canals are closed, and many of the lashes drop out from the destruction of their bulbs. In this stage of the complaint, the affected lid is often considerably everted, and, being at the same time very red and watery, it produces that peculiar state, termed *blear eye*.

As this disease is essentially of a constitutional origin, it demands more than mere topical treatment. Without entering into minutiae, it will be sufficient to remark that a steady and persistent course of purgatives, alterants, and dieting is indispensable, in almost every case, to a satisfactory and permanent cure. Blue mass and compound extract of colocynth, in five grain doses each, every fourth or fifth night, will act sufficiently upon the bowels and secretions, without weakening the system; iodide of iron and iodide of potassium will afford a good alterative effect; and bread, vegetables, and milk, will be a suitable diet. When a tonic is required, great confidence may be placed in the efficacy of iron and quinine, with a very minute quantity of opium and tartar emetic, with a view to their soothing and alterant effects.

The most valuable topical remedies are astringent lotions and stimulating unguents, properly diluted and applied by means of a camel-hair pencil. The article which has always been most beneficial in my hands is the ointment of the oxide of zinc, in the proportion of two parts to six of prepared lard. An ointment of red oxide of mercury, or of nitrate of mercury, diluted with ten times its weight of simple cerate, is also a valuable agent. Sometimes the happiest effects follow the application of a weak solution of nitrate of silver. The great secret, in the use of any article, is to make it sufficiently weak, to apply it not oftener than once, or, at most, twice, in the twenty-four hours, and to bring it fairly in contact with every portion of the diseased surface. To accomplish the latter object, care should be taken previously to remove, by weak alkaline solutions, or by means of a needle, the scaly deposits at the roots of the cilia, as well as any other matter that may have a tendency to interfere with the action of the remedy. When the lids are very red and tender, poppy fomentations, or an elm poultice, may be necessary. Agglutination of the edges of the lids is prevented by the application of a little thick cream at bedtime. In obstinate cases, counter-irritation may be proper.

12. *Lice*, generally of the family of body lice, occasionally lodge at the roots of the cilia, where they excite much irritation and itching. As their ova are deposited on the lashes like beads on a thread, a great deal of care is often required to distinguish them from the little furfuraceous scales attendant upon herpes. The most efficient remedy is a mixture of equal parts of castor oil and alcohol.

PTOSIS.

The term *ptosis* implies an inability to raise the upper lid, owing to some defect in the elevator muscle. This defect may consist in mere atony of the muscle, in paralysis of the third pair of nerves, in mechanical injury, or in hypertrophy of the common integument. Occasionally it is found to exist as a congenital vice; and in several instances of this kind I have seen it associated with divergent strabismus and permanent dilatation of the pupil. It is seldom met with simultaneously on both sides. *Ptosis* varies in degree from the slightest drooping of the lid to its complete closure, and always produces a corresponding defect in the sight, in consequence of the manner in which the affected structures conceal the cornea and pupil.

The *treatment* of this affection must be regulated by the nature of the exciting cause. When it is dependent upon mere weakness of the elevator muscle, the most

appropriate remedies will be tonics, as iron and quinine, the shower-bath, stimulating embrocations, and electricity, with change of air.

In the paralytic form, the disease often disappears spontaneously, subsiding with the cause which gave rise to it. In plethoric subjects, general and local depletion, with an occasional purgative, is sometimes necessary, in addition to the use of a small blister to the forehead and eyebrow, the surface being kept raw by means of some irritating unguent. In a case of this variety of ptosis, in a young man of twenty, under my care some years ago, I derived signal benefit, as I supposed, from the repeated application of the moxa, and powerful vesication of the occipito-cervical region.

Ptosis from hypertrophy is relieved by the excision of a portion of the redundant integument, in the form of an ellipsis, the edges of the wound being afterwards approximated by several points of suture. The operation is performed in the same manner as in entropion, and great judgment is generally required to determine the amount of substance to be removed.

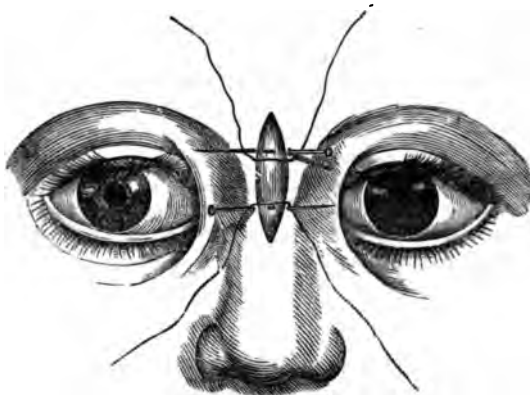
In the traumatic form, the difficulty depends upon the division of the fibres of the elevator muscle, and their consequent separation from each other. To afford relief, it has been proposed to cut out an elliptical portion of the integument of the lid, and to tack together the orbicular and occipito-frontal muscles, so as to enable the latter, by the hold thus acquired, to counteract, in some degree, the action of the former. The procedure has been employed with marked success in several instances, and is worthy of further trial, although it cannot always be expected to answer the purpose as fully as could be desired. A similar plan may be adopted in the congenital variety of ptosis.

When the affection is irremediable, or while the proper remedies are being used for its cure, temporary relief from obstruction to vision may be afforded by holding the affected lid out of the way with a piece of adhesive plaster, or by means of a small, blunt hook, attached to a pair of spectacles.

EPICANTHUS.

A very unseemly expression is sometimes imparted to the eyes by the projection over them of a redundant portion of integument at the root of the nose, concealing

Fig. 220.



Epicanthus.

the lachrymal caruncle and the inner part of the globe. It is always congenital, and occasionally exists in such a degree as to interfere materially with the opening of the lids, if not also with vision. Sichel and others have seen cases in which it was hereditary.

The treatment of epicanthus, as this affection is called, is entirely limited to the excision of the central portion of the redundant integument, in the form of an elliptical flap, the edges of the wound being afterwards approximated by the twisted suture. The result, however, is seldom satisfactory, owing to the tendency of the skin to stretch and elongate itself. In a case which I had at

the Clinic of the Jefferson Medical College in 1858, in a girl seven years of age, little, if any, permanent benefit accrued, notwithstanding the removal of a very large flap. The character of the operation and the appearance of the affection are depicted in fig. 220.

STRABISMUS.

Strabismus, or squint, as it is termed in common parlance, is an aberration of the optic axes from their natural direction, by which the consent between the eyes is

destroyed, and vision is more or less impaired. The deformity varies in different cases, from the slightest deviation to the most disagreeable obliquity. The affected organ may be turned inwards, outwards, upwards, or downwards, according to the muscle upon the derangement of which the squint depends. When it is inclined inwards, the complaint constitutes what is called convergent strabismus; if, on the other hand, it is directed outwards, it is said to be divergent. The upward and downward obliquities have not received any particular names.

The most common form, by far, of strabismus is the *convergent*, in which the eye is directed inwards, or inwards and upwards. The degree of obliquity may be very slight, or so great that when the person looks directly forwards with the sound eye, the cornea of the other shall be almost completely buried at the inner canthus. The organ, in this variety of the complaint, often inclines a little upwards, but hardly ever downwards. Divergent strabismus is comparatively rare; and the two other forms are almost unknown as separate and independent affections.

There are few cases of strabismus in which both eyes are not implicated, although not in an equal degree. Usually one is more affected than the other; the patient, therefore, always considers the latter as his good eye, as it is the one which he habitually employs in viewing objects. It rarely happens, however, that both organs become deranged simultaneously; on the contrary, one generally squints first, and, after a while, the other, the interval between the two occurrences being probably very short.

The exciting *causes* of strabismus are various. One of the most common is the habit of imitation, so general among young persons. Hence, school-rooms are a fruitful source of the mischief, the affection often spreading from one "cross-eyed" child to another until, perhaps, large numbers are involved. Statistics show that nearly one-seventh of the cases are thus induced. Ophthalmia, convulsions, eruptive diseases, as measles, scarlet fever, and smallpox, hooping-cough, derangement of the digestive organs, injuries of the head and eyes, difficult dentition, and looking fixedly at particular objects, may all be mentioned as so many exciting causes of the lesion. The most common causes of all, however, are the optical defects known as hypermetropia, or long sight, giving rise to convergent, and myopia, or short sight, producing divergent, strabismus. The affection frequently comes on without any assignable reason in the most healthy persons. I have witnessed examples in which it was congenital, and I have repeatedly known it to exist in from three to five members of the same family. There is no evidence that the complaint is hereditary. Young subjects are most liable to it.

Strabismus essentially consists in a contraction of one of the straight muscles of the eye. The shortening thus produced varies according to the extent of the squint, and is always accompanied by a corresponding elongation of the opposite muscle, so that it generally loses, either wholly or in part, its antagonizing influence. The affected muscle is not only broader and thicker than the rest, but also of a deeper color; in a word, it is hypertrophied, in accordance with a law of the economy that, in proportion as an organ is exercised, so will be its size and strength. In a few dissections which I have made of persons who died while laboring under this complaint, this condition was too manifest to escape notice, and it coincides fully with what has been observed by others in similar cases.

One of the most disagreeable concomitants of this disorder is the deformity which accompanies it, and which renders the individual so frequently an object of remark and ridicule. Were this confined to infancy and childhood, little evil would accrue from it; but when it is remembered that it continues through life, and that it is a source of constant annoyance and mortification, the influence which it exerts upon the temper of the sufferer must often be most unhappy. But there is another effect, still more deplorable, and this is the impairment of the vision of the affected eye. This defect, which is never entirely absent, always varies with the extent of the deformity and the length of time that has elapsed since its occurrence. In some instances, especially in those of long standing, the sight is almost destroyed, the retina being insensible. In another series of cases, the person is myopic, or sees objects only at a short distance. In a third series, the vision is, perhaps, double, or objects appear indistinct, or run into each other, the image depicted on the retina being confused and imperfect.

It is well known that strabismus has no tendency to spontaneous cure, but that it generally manifests a disposition to increase, especially in children of a nervous,

excitable temperament; and the question, therefore, arises, at what period ought the surgeon to interfere? My opinion is that the operation should be performed early; but, in coming to a conclusion on the subject, we should carefully weigh the circumstances of each case, as the condition of the patient, and the nature of the exciting cause of the complaint. If the child is otherwise healthy; if there has been no cerebral disease; and if the squint is fully formed, there should be no hesitation. There are valid reasons for such a course. In the first place, if the deformity is permitted to persist, the probability is that both eyes will ultimately require interference; secondly, so long as the squint remains, the subject of it will be an object of remark and ridicule; and, thirdly, the invariable tendency of the affected organ is to become weaker and weaker, in proportion to its want of exercise. Besides, children invariably bear such operations well; they are unattended with hemorrhage and shock; and chloroform is always at hand to insure the requisite quietude during their performance.

The instruments requisite in this operation are a spring speculum, to control the lids, a blunt hook to bring the tendon into view, a pair of forceps for pinching up the conjunctiva, and scissors for dividing this membrane, the ocular fascia, and the affected muscle.

I generally prefer to perform this operation without chloroform, as such a procedure affords a much better opportunity of judging of the effects of the division of the muscle. If the patient, however, is a child or a very timid person, anæsthesia will be indispensable. In either event, the body should be recumbent, with the head and shoulders well supported by pillows. The lids being then separated by the speculum, the surgeon with a pair of toothed forceps seizes a fold of conjunctiva at the lower border of the insertion of the rectus tendon and divides it with a pair of sharp-pointed scissors, in a direction parallel to the fibres of the muscle. The ocular fascia, if not included in the first incision, must be seized with the forceps and divided. The blunt hook may then be passed through these apertures, behind the tendon, rendered tense by making traction towards the cornea. One blade of a pair of blunt-pointed scissors may now be passed beneath the tendon, which is then divided by successive snips subconjunctivally, or the tendon may be brought fully into view upon the hook and severed with the scissors. Lastly, the blunt hook is passed in various directions in search of any bands or attachments that may have escaped division.

The operation being completed, the eye is bathed in cold water, to free it of blood, and the patient is confined for a few days in a dark chamber. Light diet is enjoined, inflammation is restrained by antiphlogistics, and pain controlled by anodynes. Considerable ecchymosis occasionally follows, but requires no particular treatment, as it usually disappears spontaneously in a few days. The extremity of the divided muscle contracts new adhesions to the ball of the eye, and thus aids in maintaining its parallelism after the cure is completed.

The practice, recommended by some surgeons, of making the patient turn the eye outwards as soon as he has recovered from the more immediate effects of the operation, for the purpose of causing it to regain its natural position in the orbit, is, I think, decidedly objectionable. When the eye still retains some degree of obliquity after the operation, it may positively be assumed that there has been imperfect section of the affected muscle, or of the fibrous cords connected with it. How, then, when this is the case, can we expect success? Again, the eye operated on may be perfectly straight, and yet not move in concert with its fellow. Such a result is by no means uncommon, especially in old cases, and the proper plan then is to divide at once the corresponding muscle of the other eye. In children, and in cases generally of recent standing, one operation is usually quite sufficient, even when the obliquity remains for some time after. Indeed, the greatest caution should be employed even in the division of one muscle, lest the eye be permanently inclined outwards, and so distortion be produced in the opposite direction.

The principal causes of failure after this operation are, first, as already stated, the imperfect division of the affected muscle and fascia; secondly, excision of a portion of the conjunctiva, eventuating in undue contraction of this membrane during the process of cicatrization; thirdly, premature exercise and exposure of the eye; fourthly, the coexistence of epilepsy, hydrocephalus, or other cerebral diseases; fifthly, readherence of the muscle at an unfavorable point of the sclerotic coat, by which it is again enabled to exert a prejudicial influence over the movements of the ball;

and, lastly, the fact that only one operation is performed, when it is certain that both organs are affected nearly in an equal degree. Of all these causes the first and last are the most frequent and efficient. Failure sometimes arises from the neglect to correct by suitable glasses any existing optical defect that may have been instrumental in inducing the strabismus.

The effect of the operation upon vision is at first rather disagreeable than otherwise; at least in some cases. It is only by degrees that the eye regains its functions; and occasionally, whether from long disuse of the retina, or from other causes, little or no improvement of this kind is to be looked for. Another unpleasant effect, but not a very common one, is double vision, evidently due to a want of consonance between the optic axes, but rarely continuing beyond a few days.

The operation for strabismus is performed less frequently now than formerly; chiefly because it has fallen somewhat into discredit from the numerous failures that have attended it in the hands of incompetent men, who have considered themselves qualified to undertake it, no matter how slender their anatomical knowledge and practical skill. It is not surprising, therefore, that many of the cases that have been subjected to the operation should have disappointed expectation; but these circumstances should not be used to the prejudice of an operation, calculated, when properly executed, to confer so much benefit upon this class of sufferers. The results that may be obtained are eminently gratifying, and are sufficient to show that the procedure deserves to be ranked among the established resources of surgery.

When the operation for convergent strabismus is followed, as it occasionally is, by eversion of the ball of the eye, the proper means of rectifying the defect is, to expose the divided muscle with the scissors, to sever its connections with the sclerotica, and to fasten its free extremity, by means of two very delicate silk threads, to the fibro-cellular structures in front of the eye, underneath the conjunctiva, in the natural line of the muscle. Care must be taken not to bring the muscle too far forward, otherwise the original deformity will be sure to be reproduced, thus necessitating a third operation. The sutures should be removed at a period varying from three to five days, the case, in the mean time, being treated upon general antiphlogistic principles.

AFFECTIONS OF THE ORBIT.

The orbit is subject to wounds, foreign bodies, tumors, and various diseases, seated either in its bony walls, or in its soft textures. One of their most disagreeable effects is that which arises from the pressure which they exert upon the ball of the eye, thereby thrusting it out of its natural position, and endangering its structure and functions.

Wounds of the orbit are of various kinds, and must be treated upon general principles. Special attention must be paid to the removal of foreign bodies, which often lie concealed at a great depth, and may, therefore, unless great care be exercised, readily escape detection. Copious hemorrhage often attends wounds of the orbit, but may usually be readily arrested by compression, conjoined with the use of Monsel's salt. When the ordinary means fail, ligation of the common carotid artery must be performed.

Periostitis is a violent form of inflammation, seated, as the name implies, in the fibrous covering of the orbit, from which it is sometimes propagated through the foramina in the sphenoid bone, and the fibrous sheath of the optic nerve, to the dura mater and the base of the brain. The morbid action may originate in the periosteum of the orbit, or it may extend to it from the face, temple, or forehead. The most common exciting causes are, external injury, and a syphilitic, gouty, or strumous state of the system. Children and adults of a dilapidated constitution are its most frequent subjects. The symptoms are well marked. The pain is deep-seated, constant, agonizing; the eye feels tense and full, as if it would burst, and the slightest motion of the organ is attended with an aggravation of suffering; the conjunctiva is greatly congested, and of a scarlet hue; the patient complains of intense headache and excessive photophobia; there is high fever; and delirium is an early and prominent phenomenon. If matter forms, as it will be very apt to do if the disease is permitted to proceed, its presence will be announced by rigors, and by great increase of the local and general distress, succeeded by obscure fluctuation, which will become more and more conspicuous as the suppurative process advances. Furthermore, there will, usually, in such an event, be an erysipelatous condition of the face and head, and a marked protrusion of the eyeball. If the attack is misunderstood, or

improperly treated, the disease will spread to the brain and its envelops, causing coma and death.

The best means for arresting this frightful disease are, leeches, bleeding at the arm, active purgatives, depressants, and anodynes. Tension must be relieved by punctures, and matter let out as soon as there is the slightest evidence of its existence. In performing the operation, the knife must be inserted in such a manner as not to injure the globe of the eye. The fluid is often very deep-seated. In dilapidated subjects, tonics and stimulants will usually be required, instead of depletion.

A chronic *abscess* of the orbit occasionally occurs, commonly as a consequence of disease of the bones and periosteum, or of a slow form of inflammation of the cellular and adipose tissue. The symptoms are less severe than in the acute form of the attack, and there is much less risk of serious cerebral involvement. The treatment is conducted upon general principles.

Periostitis, caries, and necrosis of the walls of the orbit are sometimes observed, chiefly in tertiary syphilis; I have met with a considerable number of such cases, and have invariably found them troublesome and tedious. When the margin of the orbit is involved, serious deformity of the lid will generally be the consequence.

Intraorbital *tumors* are of two kinds, the solid and the encysted, the former being either of a fatty, fibroid, osseous, sarcomatous, or encephaloid character. Their development generally begins deep in the socket, and instances occur, although rarely, in which they take their rise at the base of the brain, from which they gradually proceed through the openings in the sphenoid bone. However this may be, they sooner or later seriously encroach upon the ball of the eye, displacing it in different directions, and ultimately pushing it completely out of its socket. The morbid growth is commonly very tardy, except when it is of a malignant nature, when it advances with its usual rapidity. The amount of suffering attending it is variable, being sometimes extremely severe, while at other times it is remarkably slight. As the tumor increases in bulk, the eyelids are thrust apart, and rendered tumid and œdematous, the cheek swells, and the patient is distracted with circumorbital pain. In some cases the ball of the eye is merely pressed to one side by the new growth, their position being defined by a distinct line of demarcation; in general, however, they are more or less intimately blended together, especially at the optic nerve, which is not unfrequently completely surrounded by the new structure, thus rendering it extremely difficult, if not impossible, to separate them from each other.

Fig. 221.



Cystic Tumor of the Orbit.

Fig. 223.



Anastomotic Aneurism of the Orbit.

The *cystic tumor* of the orbit, fig. 221, from Mackenzie, generally contains a clear, limpid fluid, of a sero-albuminous character; sometimes, however, the contents are more or less turbid, or partly solid and partly fluid. A very curious case of encysted

tumor of the orbit, in a lad seventeen years of age, has been recorded, in which there was an imperfectly developed tooth; and Sir Everard Home met with an instance in which a cavity of this kind was filled with an inflammable oily fluid. The cyst, although usually single, is occasionally multilocular, and of extraordinary thickness and density.

Acephalocysts and *echinococci* have been observed in the orbit, but their occurrence is extremely rare, and their detection must necessarily be purely accidental.

The orbit is occasionally the seat of the *arterial tumor*, the anastomotic aneurism first described by John Bell; it is generally a congenital affection, and is capable of acquiring a great bulk, forming a characteristic pulsating growth. The annexed sketch, fig. 222, from Walton, affords a good idea of this disease, and of the influence it may exert upon the ball of the eye. The venous tumor is also occasionally met with, but its occurrence is uncommon. The ophthalmic artery is sometimes the seat of aneurism. Mr. Ernest Hart, in 1863, reported a unique case of traumatic arterio-venous aneurism of the frontal branch of this vessel, in a boy, eleven years of age. The tumor, situated at the inner angle of the orbit, just below the margin of the bone, pulsed strongly, and was attended with a perceptible thrill and a loud, whizzing bruit.

The *bones* of the orbit are subject to hypertrophy, chiefly as the result of a syphilitic taint of the system; the disease usually occurs in union with hypertrophy of the cranial bones, and may exist in such a degree as to encroach very seriously upon the ball of the eye.

Exostosis of the orbit is extremely uncommon. It may spring from any portion of the cavity, and is precisely of the same structure as an exostosis in other parts of the body. As it increases in size, it causes more or less pain by its pressure upon

Fig. 223.



Ivory Exostosis of the left Orbit.

Fig. 224.



Encephaloid of the Orbit and Antrum.

the surrounding tissues, and gradually but effectually displaces the eye, pushing it sometimes completely out of its socket. Amaurosis and total blindness are occasionally among the first symptoms of the disease. The growth not unfrequently begins very early in life. The diagnosis is generally easily determined by the history of the case, and by the remarkable firmness of the tumor, which is greater than that of any other morbid structure. The adjoining sketch, fig. 223, represents an ivory exostosis springing from the anterior part of the cranium, and filling the left orbit.

An exostosis occasionally originates in the maxillary sinus, and, passing upwards into the orbit, completely distends it, at the same time that it forms a large tumor upon the face. In the case from which the annexed drawing, fig. 224, was taken, the growth was probably of a malignant nature, as it had destroyed not only the orbit but also the malar, maxillary, and frontal bones. The osseous part which remained after maceration consisted of an oval mass of a light, porous character, five inches in diameter by four inches in length. Mr. Walton, by whom this tumor has been described, is of opinion that it might have been safely extirpated even in its latest stages, and with great ease and success at an early period. It had been five years in progress before it proved fatal.

A very remarkable case of *neuromatous tumor* of the optic nerve, causing great protrusion of the ball of the eye, has been described by Dr. J. A. Lidell, in a woman, aged twenty years, for the last eight of which she had labored under the disease. The tumor, divested of extraneous matter, was fully as large as a goose egg, of an elongated, oval shape, and of a laminated fibrous structure. It was formed by the expanded and thickened sheath of the optic nerve, and was invested by a smooth, glossy capsule of condensed cellular substance. Two cysts, filled with reddish serum, were attached to its superior surface, and imparted a sense of fluctuation to the upper eyelid. Excessive pain, of a neuralgic character, attended the case, and the symptoms closely resembled those of carcinoma. The operation was accompanied by copious hemorrhage. The woman was in good health five years afterwards.

Sarcoma is the most frequent of the malignant affections of the orbit, but does not differ here, in its general characters, from sarcoma in other parts of the body. Arising in the fatty tissue of the cavity, as glious, myxomatous, or pigmentary sarcoma, it forms large, soft, medullary, lobulated masses, which surround the optic nerve, displace and flatten the ball, by the side of which they may make their appearance at the lids, or, as in the case especially of the melanotic variety, penetrate into and nearly fill the globe. On the other hand, the structures of the orbit may be affected secondarily, a glious tumor of the retina, or a melanotic sarcoma of the choroid, perforating the sclerotica, and extending behind and around the eye. A few cases have also been observed of impaction of the orbit with a small round-celled sarcoma, which originated in the nose or maxillary sinus.

Sarcoma evinces a great disposition to disseminate itself, involving the neighboring bony cavities, as the ethmoidal cells, the frontal sinus, and the antrum of Highmore, and even extending along the course of the optic nerve to the base of the brain and its membranes. Hence, the prognosis is in the highest degree unfavorable.

The various forms of orbital tumors are often difficult of *diagnosis*. The points which should more especially claim attention with a view to an accurate discrimination are the history of the case, the consistence and progress of the morbid growth, and the presence or absence of pulsation. The solid growth may, in general, be easily distinguished by its firmness; the fluid by its softness. The fatty tumor has a doughy feel; the fibrous an elastic one. An exostosis is always remarkable for its extreme hardness. The encysted tumor of the orbit is not only soft, but distinctly fluctuates under pressure. The hydatid tumor possesses similar properties, but cannot be distinguished from the encysted, properly so called. An aneurism by anastomosis is characterized by strong pulsation, by a peculiar thrill synchronous with the contraction of the left ventricle, and by the pain which it produces in the eye, head, and face. The innocent tumor is generally tardy in its development; the malignant rapid, with a tendency to early ulceration and adjacent implication. In all cases of doubt, recourse should be had to the judicious use of the exploring needle, the instrument selected being of the smallest size.

In the examination of supposed orbital growths, the surgeon should not forget that great protrusion of the eye may be caused simply by an anemic condition of the system, by inordinate deposits of fat, by infiltration of the orbital cellular tissue consequent upon inflammation and external injury, or by exophthalmic goitre.

The *treatment* of these various formations must be conducted upon general principles, or according to the rules laid down for their management in different parts of the work. Unless there is reason to believe that they may be removed without any material detriment to the eye, the best plan will be not to meddle with them, unless it is previously understood that this organ is to be sacrificed if it be found to be seriously involved in the morbid structure. This should not, of course, be thought of so long as the abnormal growth is comparatively small, does not encroach obstructingly upon vision, nor occasion severe suffering. The situation, shape, and extent of the incisions must be regulated according to the exigencies of each particular case. When the tumor occupies the outer or inner canthus of the eye, the object may generally be attained by slitting up the lids in the direction of their commissures, otherwise it will probably be necessary to cut through their substance. In the solid tumor, complete riddance should always be aimed at.

The encysted tumor may be removed entire, or, if its connections are intricate, a portion of the wall may be left, the secreting surface being destroyed with nitrate of silver, tincture of iodine, or sulphate of copper.

For the cure of intraorbital aneurism, or supposed aneurism, the common carotid

artery has occasionally been tied. Of 30 cases analyzed in 1865 by Dr. T. G. Morton, of this city, 22 were cured, 3 perished, and 5 were unsuccessful. Of 45 cases of this operation, tabulated Dr. Noyes, of New York, in 1869, 32 were successful, 7 terminated fatally, in 2 the result was incomplete, and in 4 the pulsation of the tumor continued unabated. One of the cases was a traumatic arterio-venous aneurism, in which digital compression of the carotid had been vainly tried for three weeks.

Occasionally a cure has been effected by injections with perchloride of iron; and within the last few years, Gioppi, Vanzetti, and Freeman, have each treated a case successfully by digital compression of the common carotid. The tumor in these instances was of a formidable size; the eye protruded from its socket; the bruit was heard very loudly; and the pulsation could easily be felt by the finger inserted into the orbit. The compression was maintained intermittently for a few minutes at a time. In Gioppi's case, all pulsation ceased at the end of the fourth day; in Vanzetti's, in about two weeks and a half. In a case under the care of Dr. Harlan, compression of the carotid artery signally failed. Direct interference could only be justifiable in the earlier stages of the disease, before the morbid growth has acquired any considerable bulk.

In a case of this affection, reported by Dr. E. L. Holmes, of Chicago, a cure seems to have been effected by the conjoined use of tincture of veratrum viride and Tilden's fluid extract of ergot, administered during a period of about six weeks in such a manner as to keep up a constant and decided impression upon the heart's action.

An exostosis of the orbit has occasionally separated spontaneously, as in a remarkable case recorded in the first volume of Guy's Hospital Reports. The growth, situated at the inner part of the orbit, weighed nearly fifteen ounces. When excision is carefully performed, the patient may not only regain his sight, when this has been impaired, but the eye may ultimately return to its natural position, and recover its accustomed freedom of motion. Hypertrophy of the bones is generally irremediable.

CHAPTER VI.

DISEASES AND INJURIES OF THE EAR.

No satisfactory exploration of the ear can be made without a good light. The best light is that afforded by the direct rays of the sun; but in cloudy weather, artificial illumination will be required. The patient being seated upon a chair, with the ear inclined towards the opposite side, facing the sun, the light should be permitted to fall directly upon the tympanic membrane, as can easily be done by pulling the auricle upwards and backwards with the thumb and forefinger of one hand, while the tragus is drawn forwards with the index finger of the other. If the sun is very bright, the examination may be conducted in a room, in front of a large window, but even then it is generally preferable to make it in the open air, as transmitted light is never as satisfactory as direct. The surgeon must be careful not to obstruct the passage of the sun's rays with his own head, and he should also see that no one else interferes, as two persons can never inspect the organ at the same time. A speculum need only be used when the auditory passage is unusually narrow or studed with an uncommonly large number of hairs obstructing vision. The one which I prefer, and which will generally be found to answer every purpose for which such an instrument can be employed, is represented in fig. 225. It is very light and convenient, and may be adapted to almost any ear, however small, as its terminal extremity is not more than two lines in diameter, while its movable blades readily admit of this distance being increased to any extent compatible with the size of the canal. The speculum of Sir William Wilde,

Fig. 225.



Ear Speculum.

delineated in fig. 226, is also an excellent instrument, although I cannot perceive that it possesses any advantages over the other, except its more easy portability. The same remark is true of Mr. Toynbee's speculum, shown in fig. 227. The fact is, that these things are very much a matter of conceit or fancy, influenced often by prejudice rather than sound judgment, or the result of correct observation. Be this as it may, I am certain, from ample experience, that the eye alone is generally quite sufficient for any examination of this kind. There are cases, indeed, where the auditory canal is so sensitive as absolutely to prevent the introduction of a speculum, however gently effected.

In cloudy weather, or at night, the examination may easily be effected with the aid of a Miller's lamp, fig. 228, consisting of a reflector and a wax candle, inclosed

Fig. 226.



Wilde's Speculum.

Fig. 227.



Toynbee's Speculum.

Fig. 228.

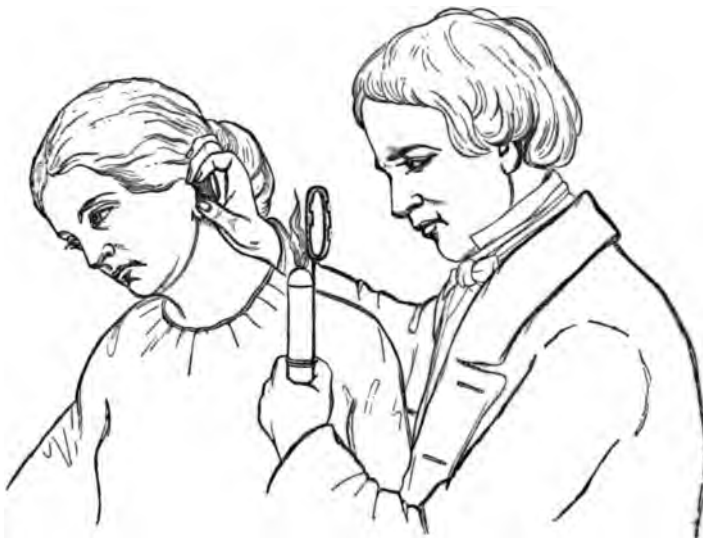


Miller's Lamp.

in a Palmer's spring tube, six inches in length, and resting upon a base two inches and a half in diameter. The top is closed with a cap. A speculum having been inserted into the ear, the light is thrown upon it by means of the lamp, the whole proceeding being conducted as represented in fig. 229, from Toynbee.

A very light, cheap, and convenient instrument for examining the ear, both with solar and artificial light, has been invented by Dr. Grant, of New Jersey. It consists, as seen in fig. 230, of a concavo-convex funnel, in which the rays are collected and thrown upon a highly polished steel mirror placed at an angle of 45°.

Fig. 229.



Miller's Lamp and the Tubular Speculum applied.

Passing directly through this mirror is a straight tube, which is armed with a powerful lens, and which can be adjusted by means of a screw to any focus. Both the funnel and tube are coated with silver, feebly polished. From this mirror the rays of light are thrown at a right angle, directly upon the membrane of the tympanum, which, together with the adjacent parts, is thus fully illuminated, the instrument having previously been adjusted in the external ear.

Perhaps the most simple and efficient of all these various contrivances for inspecting the ear is that sketched in fig. 231, devised by Weber, of Berlin, and modified

Fig. 230.



Dr. Grant's Aural Reflector.

Fig. 231.



Weber's Speculum.

by Simrock, of New York. It is simply a bivalve speculum, with a magnifying glass, throwing the light into the meatus and thus increasing the size of the membrane of the tympanum.

The method of Von Tröltsch, which is now much employed, recommends itself by its great simplicity and convenience, as the requisite degree of illumination may generally be readily effected, even in cloudy weather, without the aid of artificial light. It consists in the use of a conical speculum and a concave mirror of glass or metal, three inches in diameter, with a central aperture for the eye of the observer, and of a frontlet by which it can be secured to the forehead. It has a focal distance of about six inches. An argand gas-burner, placed in front of a large concave mirror, arranged on the movable arm of a stand similar to that employed in ophthalmoscopic inspections, afford the best artificial light, should this be deemed necessary.

While the light is thus playing about in the passage, the examiner takes a rapid survey of the appearances of the parts, noticing particularly the condition of the membrane of the tympanum, as to whether it is transparent or opaque, red, injected, convex or concave, ulcerated, perforated, or destroyed; also, the state of the auditory tube, the color and quantity of the cerumen, and, in short, everything else calculated to furnish matter of diagnostic and practical value. Should the parts be obscured, or concealed from view, by the presence of pus, wax, epithelium, or hair,

Fig. 232.

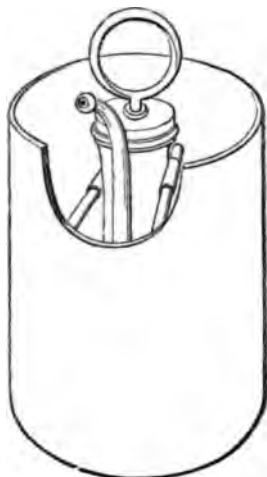


Ear Syringe.

clearance must be effected, as a preliminary step, by syringing the tube with tepid water. A very suitable instrument for this purpose is depicted in fig. 232. It must be capable of holding at least from two and a half to three ounces of fluid,

which should be thrown up with some degree of force, yet at the same time so cautiously as not to shock or pain the affected structures. It should be held firmly in the hand, with the nozzle, which should be inserted only a few lines, directed obliquely downwards and forwards, the water, as it regurgitates from the tube, being received into a large, flattish basin, held under the patient's ear and chin. A convenient contrivance, combining the arrangement of a basin and syringe, for injecting the ear, was devised by Dr. Hullihen, of Wheeling, and is represented in fig. 233. Mr. Toynbee employed what is called an ear spout, fig. 234, a kind of tin gutter, fitted closely to the head, under the ear, by means of a spring. The use of the probe is not admissible in these examinations. The forceps or scoop may occasionally be employed in the removal of solid matter. For the purpose of applying caustic, acid, and other fluids a hard rubber, glass, or porcelain speculum will be found useful.

Fig. 233.



Hullihen's Apparatus.

Fig. 234.



Ear Spout fitted on the Head.

The manner of exploring the Eustachian tube will be described along with the diseases of that passage. A watch held near the ear or placed between the teeth, will determine, by its ticking, perceived by the patient, the degree of hearing. The experiment should be repeated at each visit, and the result carefully noted, as it affords important information relative to the progress of the treatment.

Finally, to render such an examination complete, we must carefully inspect the patient's throat and tonsils, take particular notice of the state of his voice, percuss the mastoid region, and auscultate the ear while air is being forced into it along the Eustachian tube.

SECT. I.—AFFECTIONS OF THE EXTERNAL EAR.

The auricle is liable to various *malformations*. Thus, in the first place, it may be entirely absent, without any vestige whatever of an external opening. Such an affection is not necessarily attended with deafness even when it involves both organs, although audition must be much impaired. Secondly, there is occasionally an absence of the lobule of the ear; or this structure is divided, by a vertical fissure, into two portions, an anterior and a posterior; or, lastly, it is attached to the side of the head, either partially or completely. Thirdly, there may be a deficiency of the helix, this body being either wanting, or so small and flat as hardly to deserve to be considered as a distinct process. This defect is sometimes congenital, but is much oftener produced, there is reason to believe, by the pressure of the hat in early life. Fourthly, the tragus and antitragus are occasionally bilobed, or split, as it were, into two portions; sometimes they are inverted towards the meatus, thereby partially closing it; and sometimes, again, they are more or less extensively united, particularly along their lower borders, producing a similar effect. Finally, excessive development of the ear may be enumerated as one of its malformations.

In 1860, I had a case at the College Clinic, in an infant three months old, of supernumerary ears, in a very rudimentary state, situated immediately in front of the tragus, over the temporo-maxillary joint. In some instances the additional organs occupy the side of the neck.

Some of the above defects admit of remedy by surgical operation; others do not. Thus, a cleft lobule might readily be united by a procedure similar to that for hare-lip; an inverted tragus might be retrenched or excised; and abnormal adhesions might be severed by a simple dissection, a piece of lint being constantly kept during the healing process between the raw surfaces. In the case of supernumerary ears, above referred to, no difficulty was experienced in effecting thorough excision.

Wounds of the external ear are treated upon general principles. The parts being properly cleansed, the edges are closely approximated with a needle and fine thread, aided, if need be, by a few strips of isinglass plaster, which answers much better here than ordinary adhesive plaster. Should a bandage be required, it must be applied with great care and gentleness, and with the precaution of filling up the hollow between the ear and the head with cotton, wool, or lint, to ward off injurious pressure.

A *fibrous tumor*, a variety of keloid, composed essentially of dense, white, fibro-elastic tissue, is occasionally observed in the lobe of the ear, as a consequence of the perforation of this body, and the wearing of rings. I have seen at least a dozen of such cases, all, except one, in negroes. The affection is sufficiently common in this class of females in this city. Professor Stillé and Dr. William Pepper have each met with a number of examples, and cases have been reported by other practitioners. The growth is of frequent occurrence among the negroes in the Antilles, where the ornaments worn are unusually heavy and composed of brass. Young females are its most common subjects. In one instance I met with a tumor of this kind in a child three years old, whose ears had been pierced eighteen months previously. The tumor is pendulous, of tardy development, insensible, hard, and inelastic, without malignancy, although prone to recur after removal, and free from discoloration of the skin, which also retains its normal thickness and pliancy.

It is generally somewhat rounded or ovoidal in its shape, and is capable of acquiring a volume equal to that of a hen's egg. In some instances it is lobulated. It is of a fibrous structure, whitish in color, and of a dense, almost uniform consistence. A good idea of this variety of tumor is afforded by fig. 235, from one of my clinical cases. The patient was a negress, twenty years of age. The lobe had been perforated early in life, and the growth had been in progress for upwards of ten years. The remedy is excision, care being taken to save as much integument as possible, in order to prevent deformity. The edges of the wound are carefully approximated by the twisted suture.

The *sebaceous tumor* of the ear is uncommon. I have, however, met with it several times, particularly in the lobule, where it occasionally acquires a size equal to that of a filbert. It is of an irregularly globular shape, soft in consistence, free from pain and discoloration, and of slow growth, without any tendency to ulceration, features which sufficiently declare its nature. The treatment is by excision.

Hematoma of the ear, is, as the name implies, a sanguineous tumor, varying in size from a small bean to that of an almond, of a bluish-red color, more or less tender to the touch, generally seated upon the antihelix, the concha and adjacent parts, caused by pressure in lying, gradual in its formation, and occupied by blood, fluid at first and afterwards coagulated. Left to itself, it commonly slowly disappears by absorption, the contents during the progress of the disease often assuming a thin, viscid, serous character, intermixed with fibroid matter. A spontaneous cure is seldom effected without a certain degree of deformity at the site of the disease. The subjects of this singular affection are, for the most part, insane persons, and males, according to Dr. Hun, suffer much more frequently than females. Thus, of 24 cases reported by him, 23 were males. Although generally associated with incurable disease of the brain, it is occasionally the result of violence, and is then of more favorable import. The treatment is by sorbefacient remedies, aided, if necessary, by

Fig. 235.



Keloid Tumor of the Ear.

evacuation. Dr. Gray, of Utica, has suggested ligation of the posterior auricular artery.

Epithelioma of the ear is seen chiefly in elderly persons. It is most common in the lobule, commencing in the skin, from which it gradually extends to the other structures. The resulting ulcer is callous, painful, intractable, and bathed with a thin, foul, sanious discharge. In some cases, as in several that have been under my observation, the entire ear is eventually involved, leading to great suffering and disgusting deformity. The treatment must be conducted upon general principles.

Nævus of the external ear is uncommon. A few examples of it have, however, fallen under my observation. The affection is easily recognized, and must be treated upon the same general principles as *nævus* in other situations; by subcutaneous ligation in the milder forms, and by excision in the more severe. Amputation may be necessary when the tumor is very large, or when it has completely disorganized the original structures, and is a source of serious disfigurement and annoyance.

Great *deformity* of the ear, with extraordinary induration, is sometimes met with, chiefly in elderly females, from repeated attacks of erysipelas, eczema, and other eruptive affections. The immediate cause of the disorder

seems to be the retention and organization of the plastic matter that is poured out during the progress of these diseases. The auricle is thus rendered hard, lumpy, and inflexible, so as to resemble a piece of thick, wet sole leather; it is somewhat shortened in the antero-posterior diameter, and the meatus is so much encroached upon as to look like a mere slit. The skin is of a dusky brownish color, and the seat of more or less itching. The disease, which is generally tedious and troublesome, requires a mild course of alteratives, the best local application being zinc, copper, and citrine ointment. In obstinate cases gentle ptyalism may be necessary. The annexed cut, fig. 236, from Wilde, affords a good illustration of the nature of this affection.

A very unseemly *fissure* is sometimes found in the lobe of the ear, from the accidental tearing out of the ear-ring. The mishap is usually caused by the infant as it lies at the breast, watching the ornament. I have several times met with it on both sides. The treatment consists in refreshing the edges of the cleft, and in approximating them by suture.

Fig. 236.
Deformity and Induration of the Ear from Chronic Erysipelas.

White, *chalky* or plaster-like concretions, occupying the lobe of the ear, within the helix, are occasionally met with, as the result of a gouty diathesis. They occur as small, round prominences immediately beneath the skin, and are composed of the same material as articular tophi, uric acid crystals, very delicate, needle-shaped, and of all possible sizes, forming conspicuous ingredients. Left to themselves, these concretions are sometimes eliminated spontaneously, a slight scar marking their exit. When they are productive of pain and irritation, they may be liberated by a small incision, aided by pressure.

SECT. II.—AFFECTIONS OF THE AUDITORY TUBE.

The auditory tube is liable to malformations, the introduction of foreign bodies, accumulations of wax, morbid growths, and various forms of inflammation.

1. *Malformations*.—The most common malformation of this passage is occlusion of its external orifice by an extension of the common integument, producing a condition similar to that occasionally met with in the anus, vagina, and other mucous outlets. A person thus affected is not always deaf, although his hearing must of necessity be very defective. The cutaneous cover may be very thin, consisting, perhaps, merely of a sort of translucent layer, but, in general, it is quite thick and opaque; it may be the only aberration, or it may be associated with absence of the auricle. Such a malformation obviously admits of easy relief. All that is necessary is to make a crucial incision in the situation of the natural orifice, to remove the angles of the wound, and to prevent reunion by the interposition of tents of gradually increasing sizes. But there is another case where relief is

either impracticable, or where patency can be established only after much trouble and delay. This is where the occlusion is effected by fibrous or fibro-cartilaginous matter, extending some distance down the passage, but not completely obliterating it. Here only the most cautious and patient attention will be likely to be of any avail. The dissection is made in the direction of the tube, the ear being drawn upwards and backwards during the operation. Reunion is prevented by the steady and protracted use of tents. Of course no operation is attempted when the tube is entirely impervious, or, more properly speaking, when none whatever exists. The use of a delicate exploring needle will be of great assistance in the investigation of these various conditions of the ear.

Finally, children are occasionally born with the ears completely filled with the unctuous matter which covers the skin, and which is probably derived either from the sebaceous follicles, as a depurative secretion, or from the amniotic fluid. However this may be, if the matter is allowed to remain, the deafness, which was at first, perhaps, only partial, may, in time, become complete; or the adventitious substance, acting as a foreign body, may excite inflammation, and ultimately lead to destruction of the tympanic membrane. Clearance is effected by means of the syringe and tepid water, aided, if necessary, by the scoop. A few drops of oil, or glycerine, poured upon the mass, might assist in detaching it.

2. *Foreign Bodies*.—Substances of various kinds find their way into the auditory tube, either by accident or design. The most common are grains of corn and coffee, beans, peas, cherry-stones, beads, pebbles, pellets of paper, wool, cotton, bugs, and flies. Insects sometimes deposit their larvæ in the ear, being evidently attracted thither by purulent discharge, which, if at all abundant, may afterwards serve as a nidus for the development of the new being. It is surprising that pins, which are so frequently used by females for picking and scratching the ear, do not more frequently drop into the tube than they seem to do.

The effects occasioned by the presence of a foreign body in the ear vary according to its nature, size, and shape. If it be a grain of corn, bean, or similar substance, it will, if retained for a few days, not only expand under the influence of the moisture of the part, but, perhaps, even germinate, thereby causing severe pressure upon the parts in which it is impacted, and increased difficulty in respect to its extraction. No such effect, of course, follows if the body is of an inorganic nature. Nevertheless, any substance, whatever may be its character, may, by its pressure alone, induce severe pain and inflammation, eventuating in an abundant discharge of matter, excessive constitutional irritation, headache, and delirium. A large substance generally causes more trouble than a small one, a rough than a smooth, a heavy than a light, a sharp than a blunt. A foreign body may excite ulceration of the membrane of the tympanum, and thus finally make its way into the middle ear; an occurrence which is sure to be followed by severe suffering, if not death.

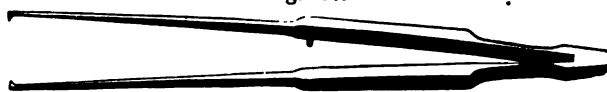
Maggot developed in the ear have been known to cause the most intense distress, such as violent pain, buzzing noises, and a sensation of gnawing or rasping of the drum. Several cases have been reported, among others one by Dr. Routh, of London, in which convulsions were thus produced.

In gunshot injuries, the ball sometimes lodges in this tube, or in this tube and the petrous portion of the temporal bone. Dr. F. F. Maury has been so kind as to show me a case in which a body of this description had been impacted upwards of a year, in the right ear of a young man who was shot at the battle of Chancellorsville, in 1863, without causing any other inconvenience than slight deafness, and occasional dizziness. The ball had entered through the zygomatic fossa, and could easily be felt with the probe. Instances are recorded where violent neuralgia, paralysis, epilepsy, and even mania were induced by the protracted sojourn of an extraneous substance in the ear. On the other hand, a foreign body will occasionally remain in the auditory tube for a long time without occasioning the slightest mischief. Not long ago, a girl, aged eleven years, was brought to the College Clinic with a large cherry-stone in the right ear, in which it had been harmlessly impacted for seven years. Dr. William H. Wenrich, of Pennsylvania, has furnished to me the particulars of a case in which a body of this kind had remained deep in the meatus for thirty-one years, without having produced any other effect than slight neuralgia a short time prior to its removal, which was accomplished by means of a bent probe and a pair of forceps.

The removal of a foreign body from the ear is by no means always an easy

undertaking. The difficulty, generally of itself sufficiently great, is frequently very much enhanced by the tortuous, contracted, or constricted condition of the auditory tube, and by the pain, tumefaction, and discharge which are likely to be present whenever the substance has been retained for any length of time. Various methods may be employed for accomplishing the object, the choice of which must be regulated by the circumstances of each individual case. If the body is relatively small to the size of the tube, and not very rough or heavy, dislodgment may usually be effected with the syringe, charged with tepid water, the fluid being thrown up in a full, steady, and forcible stream, with sufficient care, of course, not to injure the drum. This procedure should always be employed when the substance lies deeply in the auditory passage; for, although it may not cause its expulsion, it will often bring it within reach, and thus favor extraction. During the operation, or, rather, as a preliminary step, the ear should be drawn upwards, outwards, and backwards, so as to efface the angle of the canal. The syringe, which should hold at least four ounces, should have a long, slender nozzle, in order that the current may pass readily by the side of the foreign body.

Fig. 237.



Toothed Forceps.

When the substance is comparatively superficial, it may frequently be seized and extracted without difficulty, the best instrument for this purpose being a pair of very delicate toothed forceps, fig. 237, or the rectangular forceps of Toynbee, fig. 238. But such a procedure is not admissible when the substance is smooth,

Fig. 238.



Toynbee's Rectangular Forceps.

hard, or deep seated; for, in the former case, the instrument will be likely to slip off, and, in the latter, it will be impossible to give the blades the requisite degree of expansion for grasping it. If, under such circumstances, the surgeon is determined to succeed, his efforts cannot fail to be productive of serious mischief. The foreign substance will be thrust about in various directions, and perhaps pressed rudely against the membrane of the tympanum, until it is buried in blood, and the patient is put in great

agony. Cases have occurred where the surgeon, in his anxiety not to be baffled, severely lacerated the auditory tube and even the drum of the ear, causing violent inflammation, followed by death.

For a number of years past, I have depended entirely, in these operations on the ear, upon the use of the little instrument represented in fig. 239. It is composed

Fig. 239.



Instrument for the Removal of Foreign Matter from the Ear.

of steel, is five inches in length, and is now regularly put up in the ordinary pocket-case, manufactured in this city. One extremity is spoon-shaped, while the other, which is exceedingly narrow, is provided with a very delicate tooth placed at a right angle. The small end is the one which I generally prefer, as it may always be easily insinuated between the auditory tube and the intruder, which is then gently dislodged, the instrument acting either as a lever or a hook, or both, according to circumstances. The large extremity is best adapted to the extraction of wax. Such a contrivance, as I know from repeated trials, is incomparably superior for the removal of all kinds of foreign bodies to the syringe and the forceps, however ingeniously constructed or dexterously managed. As to the ordinary pocket probe, bent at the point, no sensible surgeon ever employs it.

Children are often brought to the surgeon with the ear in a high state of inflammation from previous attempts at extraction. In such a case, the proper plan is to wait until, by warm anodyne fomentations, the application of a few leeches over the mastoid process, and the administration of a brisk cathartic, the morbid action has been sufficiently subdued to justify further interference.

When a foreign body finds its way into the middle ear, through an opening in the drum, dislodgment will be extremely difficult, if not impossible. Deleau relates a case of a small pebble imbedded in this cavity, in which he effected clearance by throwing a stream of warm water into it through the Eustachian tube.

Insects and maggots are generally easily dislodged with the syringe. It is only when they are of large size, or much expanded, that forceps, hooks, or curettes will be likely to be required. When a suitable instrument is not at hand, they should instantly be destroyed, or forced out of their hiding-place, by filling the ear with olive oil, tepid mucilage, or a mixture of spirit of camphor and water.

Finally, in all operations of this kind, it is of the utmost importance that the head should be properly supported by an assistant, and resistance counteracted by the use of anæsthetics. Unless this be done, the procedure will be one of great difficulty, and attended with severe pain, if not serious injury to the parts.

The hairs which naturally grow upon the tragus occasionally attain an extraordinary length, and, projecting inwards towards the bottom of the meatus, may thus fret the drum of the ear and the ceruminous glands, causing discharge and more or less uneasiness, as in several cases reported by Dr. Robert F. Weir. The proper remedy is removal of the offending structures. In obstinate cases, destruction of the hair follicles may be necessary.

3. *Accumulations of Wax.*—This substance sometimes collects in such quantities in the auditory tube as to produce complete occlusion; at other times the obstruction is only partial, attention being directed to the subject before the accumulation has made much progress. The effects, in either case, are more or less noise in the ear, generally of a buzzing, ringing, or explosive character, and impairment of hearing on the affected side. Occasionally there is complete deafness. This result may depend solely upon the long disuse of the ear from the protracted retention of the secretion, or it may be produced by the pressure of the wax upon the membrane of the tympanum, eventuating in organic disease of its substance, as ulceration, induration, or thickening.

When the wax is very hard and dry and the meatus is completely impacted with it, it may press so hard against the tympanic membrane as to cause constant giddiness, often conjoined with a sense of weight and fulness in the head, confusion of ideas, and tottering in walking.

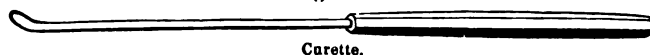
An accumulation of wax does not necessarily imply an inordinate secretion of this substance; on the contrary, it may be deposited unusually sparingly, and yet, owing to its inspissated character, it may proceed until it completely fills the external meatus. Indeed, so long as this secretion retains its natural qualities, and no obstacle is offered to its evacuation, it seldom manifests a disposition to collect; but such an occurrence is very liable to take place when it is deprived of its fluidity from exposure to the air, and other causes. However this may be, whenever the wax is long retained it is always remarkably hard and tough, and then often contains a considerable quantity of hair and epidermic scales, the whole forming a dry, almost pulverulent mass, accurately moulded to the auditory tube, excluding the air, and inducing more or less deafness. The presence of the substance is generally easily detected by its dark brown or blackish appearance, and by our inability to discover the membrane of the tympanum.

Collections of wax occur at all periods of life; and they are generally caused either by suppression of the cutaneous perspiration, by the admixture of dust with the cerumen, by disorder of the general health, or by disease of the auditory tube.

Ear-wax being in great measure soluble in water, the best method of softening and detaching it is to throw this fluid freely into the auditory tube with a large syringe with a slender, narrow nozzle. The water should always be used warm, and its efficacy will be much increased if it be mixed with a small quantity of soap and ether, or carbonate of soda, as half a drachm to the ounce of fluid, which, by combining chemically with the wax, gradually convert it into an oleaginous mass. Many practitioners are in the habit of employing oil for this purpose, but, as this substance is destitute of soluble properties, the only way in which it can prove serviceable is by

lubricating the walls of the external meatus. A much better article would be glycerine. When the wax is very abundant, or firmly impacted in the tube, I am in the habit of attacking it at once with the spoon-shaped extremity of the instrument delineated in fig. 239, or with an ordinary curette, fig. 240. Care must be taken, in performing the operation, to proceed as gently as possible, picking out piece after piece, until the whole mass has been removed, as the long retention of this substance always renders the parts remarkably sensitive. Should any fragments remain at the sides and bottom of the cavity, they may afterwards easily be dislodged with the syringe and tepid water. Clearance having been effected, all that is necessary is to

Fig. 240.



Curette.

protect the ear, provided it is unusually tender, with a pellet of cotton to exclude the air; otherwise, even this precaution may be dispensed with. When the drum is very vascular, inflamed, or ulcerated, it will be proper to apply a few leeches over the mastoid process, to cover the ear with cloths wrung out of hot water, and to administer an anodyne diaphoretic. When the tendency to reaccumulation continues, the ear should be frequently syringed, and means employed to check the inordinate action of the ceruminous glands, upon which it depends, by the use of purgatives and attention to the general health, which is often much disordered.

Several remarkable cases are recorded of persons who, after having been long deaf, were suddenly relieved by the discharge of hard plugs of wax during bathing, the expulsion having generally taken place with a loud report, like that of a small pistol. Such an occurrence can only be explained by supposing either that the steam of the hot water, penetrating the meatus, softens the indurated mass; or, what is more plausible, that the bathing excites perspiration in the walls of the tube, thus detaching the substance, the noise being produced by the rarefaction of the atmosphere behind it.

4. *Polypoid, Fungous, Parasitic, and other Growths.*—There are two distinct kinds of morbid growths in the ear, the polypoid and fungous, the former of which are similar to the tumors which are so often observed in the nose and other mucous canals, while the other essentially consist of a mass of granulations, bearing only a faint and distant resemblance to genuine polyps.

Of *polyps* of the ear there are several varieties, of which the most common are the fibro-vascular, gelatinoid, and papillary. Their structure is sufficiently indicated by their names. They are generally somewhat of a conical, pyriform, or globular shape, having a small, narrow pedicle, by which they are attached to the surface from which they grow, which is usually the posterior wall of the meatus, at the site of the ceruminous glands, or in their immediate vicinity. Occasionally, although rarely, they spring from the membrane of the tympanum itself, or very low down in the tube. Their surface is commonly smooth, and of a florid, pale, or pink hue, according to the character of their structure, or, rather, the extent of their vascularity. A polyp of the ear has sometimes the form, color, and consistence of a mulberry, or of a bunch of small grapes. Their number rarely exceeds one, unless they are very small, when they may be multiple. As they increase in size, they gradually approach the external orifice of the ear, and sometimes partially fill up the concha, forming a hard, cuticular mass, several shades lighter than the part which is buried in the tube, and also much less sensitive.

These bodies, of whatever structure, size, or shape, are attended with more or less discharge, which is either of a thin, sallow, or truly purulent character, very fetid, and often so acrid as to erode the surrounding surface. The hearing is always impaired, and in many cases completely destroyed. The nature of the tumor is easily recognized by its history and appearance. Its point of attachment is generally ascertainable with the probe, which may be readily insinuated between the growth and the auditory tube, no matter what may be its age.

The annexed sketch, fig. 241, represents a gelatinoid polyp, which I removed from the right ear of a man of twenty-six, where it had been growing for nearly three years. It was attached to the floor of the meatus, not quite as low down as its centre, by a narrow, slender pedicle, the base protruding slightly at the outer orifice. It was of a pale, whitish color, like an oyster, somewhat elastic, insensible, and

smooth on the surface, with here and there a straggling vessel ramifying beneath its lining membrane. The drawing is of the natural size. Fig. 242, copied from Wilde, represents a singularly lobulated form of aural polyp. Fig. 243, from a

Fig. 241.



Gelatinoid Polyp.

Fig. 242.



Lobulated Polyp.

Fig. 243.

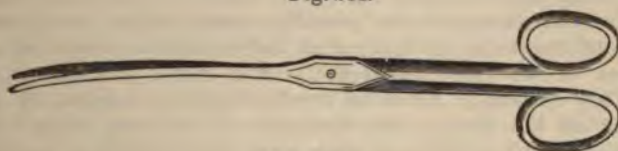


Microscopical characters of a Fibroid Polyp.

drawing by Dr. Packard, illustrates the microscopical characters of a recurring fibroid polyp, which I removed from the ear of a young woman at the College clinic. It occupied the whole of the auditory tube, and had already been operated upon twice.

Polyps of the ear are best removed by avulsion with a pair of delicate forceps, either straight or curved, as in fig. 244, applied, if possible, close to their pedicle,

Fig. 244.



Ear Forceps.

and rotated upon their axis. If a portion of the tumor is left behind, deep in the cavity, it may be scraped away with a curette, cut off with a pair of cornea scissors, or thoroughly rubbed with a stick of sulphate of copper. Instruments have been devised for ligating these growths; but, excepting the ingenuity expended upon their construction, they have little to recommend them. Fig. 245 represents the aural

Fig. 245.



Wilde's Aural Noose.

noose of Wilde. A very ingenious and useful wire snare for the removal of aural polyps has been devised by Dr. Blake, of Boston. Caustics should never be employed for removing polyps of the ear, as it is extremely difficult so to regulate the application as to prevent pain and other mischief. When there is a strong repullulating tendency, recourse may be had to the cautious use of nitrate of silver, sulphate of copper, dilute acid nitrate of mercury, or, what is better than all, chromic acid.

Fungous growths of the ear are much more common than polyps. They consist, essentially, of a mass of granulations, of a soft, spongy consistence, and of a pale,

florid color, which have their origin generally in an ulcerated condition of the auditory passage, the membrane of the tympanum, or the tube and drum together. Occasionally, the immediate cause of their production is necrosis of the petrous portion of the temporal bone, or disease of the ossicles of the ear. However induced, the growth often attains a large volume, filling up the meatus, and projecting sometimes a considerable distance into the concha. It is often quite sensitive, readily bleeds when rudely touched, and is always attended with a profuse, foul discharge.

As these formations are always of a secondary nature, it is evident that they cannot be permanently cured until the cause, under the influence of which they are developed, has been effectually eradicated. The first object of the treatment, therefore, should be to get rid of the primary affection, whatever this may be. Meanwhile, however, any exuberant growth is removed either with the scissors, the knife, or the forceps, as may seem most convenient, repression being afterwards controlled by the cautious application of the ordinary escharotics. Cleanliness is an object of paramount importance in this form of the affection, and is best promoted by the frequent use of injections of tepid water, with castile soap and a small quantity of the chlorides.

Parasitic growths in the external auditory tube have of late years attracted much attention, on account of the unpleasant effects which they may occasion, as inflammation, suppuration, noises in the ear, pain, and even deafness. The most common forms of these parasitic growths hitherto seen are the *aspergilli*, as they are termed, to which others will no doubt be added by future observers. They are usually buried in the morbid secretions, as pus, lymph, cerumen, and epithelial scales, so common in chronic, as well as in some acute, diseases of the ear, and their presence is always attended with preternatural vascularity and other evidences of inflammation of the meatus, and also frequently of the membrane of the tympanum, which, in the more simple cases, is usually covered with a thin, whitish incrustation, almost characteristic of the nature of the affection. These sporules occur at all periods of life, often multiply with great rapidity, and are generally readily destroyed by very weak solutions of hydrochlorate of ammonia, chloride of lime, and common salt.

The meatus is subject to *osseous growths*, caused either by hypertrophy of the osseous portion of the tube, by protracted inflammation, simple or specific, or by the development of veritable exostoses. The latter formations are the most common, and they generally occur as small, irregular masses, of variable shape and size, having all the density and firmness of ordinary bone. Lying immediately beneath the lining membrane, they arise from different parts of the tube, which they sometimes so completely occlude as to occasion permanent deafness, and other suffering, as pain in the ear and various kinds of noises. Two, three, and even four of such growths have been found in the same subject. They are always easily distinguished by the tardiness of their development, and by their great hardness, as revealed by the contact of the probe. Now and then they project at the orifice of the meatus. When they excite ulceration, there is always more or less discharge of fetid matter; or, instead of this, the matter may find its way through the tympanum into the middle ear, where, not meeting with a ready outlet, it may produce intense distress. An exostosis, developed deep in the passage, may destroy the tympanum, and even encroach more or less seriously upon the vestibule and auditory nerve.

The treatment of these growths is altogether unsatisfactory. In their earlier stages, their progress may sometimes be arrested, and their volume even considerably diminished, by the careful application of dilute tincture of iodine; but, as a general rule, all such efforts are unavailing. When the tumor is situated near the orifice of the tube, and has a very narrow attachment, it may sometimes be safely removed with the gouge or chisel. A very delicate trephine might advantageously be employed when the tumor fills the entire tube and impedes the flow of matter. The bony growth might thus be broken up, and removed piecemeal, or, at all events, a hole might be drilled through its centre, answering the purpose of a subsidiary canal, for the escape of pus and the introduction of medicated fluids.

A *sebaceous tumor* occasionally forms in this tube. Mr. Toynbee, who first called attention to it, in 1861, states that it may acquire a considerable bulk, and that its presence is rarely suspected until it causes deafness, more or less discharge, or cerebral disturbance. If permitted to proceed, it may produce absorption of the mastoid cells, tympanum, or petrous bone, and thus lead to very serious, if not

fatal, consequences. Its softness and elasticity readily distinguish it from bony tumors of the meatus. The only remedy is thorough excision.

The *molluscous tumor* of the meatus is very uncommon. It consists of a whitish substance, lamelliform in its arrangement, and is essentially composed of scaly matter, of variable size and shape. It has its origin, apparently, in the dermoid tissue, from which it gradually encroaches upon the tube until it fills its entire caliber, causing more or less pain, buzzing, discharge, and other unpleasant symptoms. When the tumor is unusually bulky, it may occasion partial absorption of the osseous wall of the meatus; and Mr. Toynbee has described cases in which it extended even into the cranial cavity. Fig. 246, copied from his work on the ear, affords an illustration of such a growth.

A molluscous tumor of the meatus may be mistaken for a polyp, or a mass of unhealthy granulations consequent upon caries, necrosis, or hypertrophy of the osseous wall. Error will be most likely to arise when the growth is attended with profuse discharge. The tardy progress of the excrescence, and its whitish appearance, however, are generally sufficiently characteristic. If any doubt exist, the examination of a particle of the morbid mass under the microscope will at once reveal its true nature by the disclosure of its scaly structure.

The only effective remedy is removal of the growth with the scoop and forceps, aided by the free use of the syringe, charged with tepid water. Repullulation is prevented by the cautious application of nitrate of silver.

Malignant tumors are sometimes developed in this situation, commencing either in the soft structures, in the petrous portion of the temporal bone, or in the mastoid process. Whether certain forms of polyps or of fungoid excrescences, described in the preceding paragraphs, are capable of assuming this kind of action remains to be determined, but such a conclusion is certainly not unreasonable. However this may be, the malignant growth is, in general, easily recognized by the peculiarity of its color, which is always purple or livid, by the rapidity of its development, by its tendency to extend, not only outwardly, but laterally, in every direction, by its speedy reproduction after removal, by the almost insupportable fetor of the discharge, by the excessive pain, and, lastly, by the early involvement of the neighboring lymphatic glands. The constitution gradually becomes affected, and the patient at length sinks under all the symptoms of the cancerous cachexia, or he dies suddenly, and, perhaps, unexpectedly, from effusion upon the brain. The treatment is wholly palliative.

Syphilitic affections, chiefly in the form of fissures and condylomatous excrescences, are liable to occur around the orifice of the meatus, causing more or less irritation and discharge. They are usually associated with syphilis in other parts of the body, and must be treated upon the same general principles. It is not improbable that disease here occasionally results from direct inoculation.

5. *Inflammation*.—The most common variety of inflammation of the auditory tube is the simple, which usually begins in the skin and cellular tissue, from which it often extends to the periosteum, and even to the superficial portion of the bone. The disease, in the severity of suffering which it induces, bears a very striking resemblance to paronychia. It is usually ushered in by a dull, aching sensation, which is soon converted into a violent throbbing pain, attended with a feeling of weight and obstruction, and various kinds of noises in the ear. The swelling is slow, but as it proceeds it often causes complete occlusion of the tube, and involves the parts around the ear, which are always exquisitely tender, and intolerant of the slightest pressure and motion. When the disease is at its height, the patient is unable to masticate, and to lie on the affected side. Headache and constitutional disturbance generally attend, and there is, in most cases, a strong tendency to suppuration, the matter being, however, always small in quantity, but deep seated.

The origin of this disease is not well understood. It is often witnessed in per-

Fig. 246.



Molluscous Tumor.

sons who are, apparently, in the most robust health. In general, however, it arises from cold, or a disordered state of the digestive organs from over-feeding, intemperance, and other causes. Occasionally it occurs as a sequel of measles, scarlatina, typhoid fever, or smallpox. When the inflammation attacks an individual already much debilitated by disease, it may prove dangerous by involvement of the brain and arachnoid membrane. When an abscess forms, the matter discharges itself either into the auditory tube, or it finds an outlet in the immediate vicinity of the ear, either just in front of the temporo-maxillary articulation, or over the root of the mastoid process.

The treatment must be rigidly antiphlogistic. If the symptoms are urgent, and the patient is robust, it may be necessary to take blood from the arm, to purge him actively, and to subject him to the use of the antimonial and saline mixture, with anodynes to allay pain and procure sleep. In general, however, these remedies may be dispensed with, as the object may readily be attained by the application of leeches to the anterior and posterior part of the ear, anodyne fomentations, light diet, and diaphoretics, especially if an early and free incision is made, which is often just as necessary here as in whitlow, or in an ordinary phlegmonous boil. The opening should be deep rather than extensive, reaching down to the bone, so as to afford free vent to the confined fluid. When the disease is slow in disappearing, or when abscess after abscess forms, a course of alterative and tonic medicine will be indicated, along with a proper regulation of the diet, and change of air.

This disease occasionally assumes an erysipelatous type, or it may possess this character from the commencement. Its nature will be denoted by the peculiar discoloration of the skin, by the presence of minute vesicles, by the tendency of the morbid action to spread over the surrounding parts, and by the peculiar burning, itching, or stinging character of the pain. The treatment does not differ essentially from that necessary in the preceding case, only that the inflamed surface should be painted freely with dilute tincture of iodine, and that, if matter form, the incision should be somewhat more extensive.

6. *Herpetic Affections.*—The auditory passage is occasionally the seat of herpetic disease, either as a primary affection, or as a propagation from the auricle, where it is by no means uncommon. It is characterized by the formation of numerous vesicles, generally more minute than the smallest pin-head, closely grouped together, if not confluent, and filled with a thin, whitish, or slightly yellowish fluid. The surface upon which the eruption rests is of a dusky-reddish appearance, and the seat of intolerable itching. When the vesicles break, they are replaced by little ulcers, chaps, or fissures, discharging a thin, sanious fluid, which may be so copious as to run out upon the ear, and even upon the patient's pillow. The auditory tube is red, swollen, angry looking, tender, and, at times, even quite painful from the great extent of disease. The suffering is increased by exposure, by the use of stimulating food, and by disorder of the alimentary canal. The affection may last for years, and finally extend to the membrane of the tympanum. Besides the itching, which is always a prominent symptom, the patient is troubled with noises in the ears, and with partial deafness.

In the treatment of this affection, particular attention must be paid to the state of the general health, which always exercises a remarkable influence upon its progress and duration. The secretions must be improved by a mild course of alteratives, the diet must be plain and non-stimulant, and the bowels must be moved from time to time with vegetable cathartics. If the patient is robust, the antimonial and saline mixture may be of service; while in obstinate cases it may be necessary to have recourse to gentle ptyalism, followed by the use of iodide of potassium. In weak, debilitated states of the system, the most appropriate internal remedies are tincture of chloride of iron and Fowler's solution of arsenic, twenty-five drops of the former and eight to ten of the latter being given thrice a day. The best local applications, at the commencement of the treatment, are leeches with warm water-dressing, and afterwards, when the morbid action has been somewhat moderated, weak solutions of bichloride of mercury, acetate of lead, or, what I prefer to everything else, benzoated ointment of oxide of zinc.

7. *Inflammation of the Ceruminous Glands.*—The glands which secrete the wax of the ear are liable to inflammation, either from the suppression of the cutaneous perspiration, disorder of the digestive apparatus, the extension of some specific dis-

ease, irritation of the gums, as in teething, or the presence of a foreign body. Its characteristic is an inordinate secretion of cerumen, accompanied with a sense of fullness and uneasiness deep in the auditory tube, which is at the same time, perhaps, considerably swollen, though rarely as much as in the more common forms of inflammation. The wax is of a pale-yellowish color, of a thin consistence, almost like water, and so abundant as to run out of the ear in considerable quantity. If it be allowed to remain, it closes up the passage, becoming thick and hard, of a dark-brownish, or blackish color, and firmly adherent to the walls of the tube. Ordinarily there is little or no impairment of the hearing, but there is nearly always more or less noise in the ear, especially when the disease extends to the membrane of the tympanum, when there is occasionally also considerable deafness.

The treatment of this inflammation does not differ from that of the more ordinary forms. An active purgative with light diet, and a few leeches behind the ear, generally suffice to put a speedy stop to the morbid action. If the disease has been the result of cold, benefit will arise from the use of diaphoretics, as Dover's powder or a combination of antimony and morphia. To clear away the wax, tepid water, containing a little soap, should be gently injected into the ear, followed by some mildly astringent lotion, as a very weak solution of nitrate of silver, acetate of lead, or sulphate of copper and tannic acid.

8. *Hemorrhage*.—Hemorrhage of the ear is a rare occurrence. It may be the result of external injury, or of ulceration of a tolerably large vessel, and may have its seat either in the auditory tube, in the cavity of the tympanum, or in the parts immediately around the petrous portion of the temporal bone. Cases have occurred where the bleeding was so large and unmanageable as to lead to the belief that it proceeded from the internal carotid artery, laid open by an extension of the morbid action from the ear. The blood, in these cases, gushed out of the meatus in immense quantities, and, although it could be temporarily controlled, it ultimately caused death by exhaustion. When it proceeds from, or passes through, the cavity of the tympanum, it also escapes at the Eustachian tube, from which it is either ejected along the mouth, or, as is more common, it descends into the stomach. In fractures of the base of the skull, involving the meninges and the petrous portion of the temporal bone, there is often a copious discharge from the ear, at first of pure blood, and afterwards of sanguineous serum. Sometimes the bleeding is vicarious of the menstrual flux.

Aural hemorrhage is treated in the same manner as hemorrhage in other parts of the body; by attention to position, the exhibition of opium and acetate of lead, cold applications to the mastoid process and the back of the head, and the use of the tampon. When the blood issues from the fauces, the Eustachian tube should be plugged with the catheter, its extremity being surrounded by a bit of sponge to secure more accurate closure.

SECT. III.—DISEASES OF THE MEMBRANE OF THE TYMPANUM.

1. *Wounds and Lacerations*.—The membrane of the tympanum is liable to various kinds of wounds, either as a result of violence directly applied, or as concomitants of fractures of the skull. In the latter case it is probably more frequently injured than is generally supposed. It is an interesting fact to know that, when the lesion is not too extensive, it is readily repaired by an effusion of plastic matter, the process employed by nature being the same as in the healing of wounds in other parts of the body. Independently of clinical observation, which long ago established the fact, the experiments of Valsalva are perfectly conclusive upon the subject, proving that wounds of this membrane are susceptible of cicatrization, even when they are accompanied by considerable loss of substance. This distinguished physician repeatedly perforated and even lacerated the membrane of the tympanum in dogs, which, after some time, he killed, when he found that the injury had been most thoroughly repaired in every instance. Similar experiments have been performed since the time of Valsalva by physiologists and surgeons, with precisely similar results. In the operation of excising a portion of the membrane for the cure of deafness, formerly so much in vogue, the great trouble has been to prevent the opening from closing. From all these facts, then, we may deduce the interesting conclusion that wounds of this membrane, even when attended with considerable loss of substance, are, in general, easily repaired. To promote this occurrence, in case of accident,

the treatment should be strictly antiphlogistic, particular attention being paid to the position of the head, and free use being made of leeches behind the ear.

Rupture of the membrane of the tympanum may be produced in several ways, as a fall upon the side of the head, a box on the ear, blowing of the nose, and the forcible introduction of a foreign body, as exhibited in the accompanying sketches, figs. 247, 248, 249, from Toynbee. I have met with several cases in which it was

Fig. 247.



A Fissure in the Lower Part of the Tympanic Membrane from a Box on the Ear.

Fig. 248.



A Fissure in the Posterior Part of the Tympanic Membrane from Blowing the Nose.

Fig. 249.



A Fissure in the Tympanic Membrane caused by a Twig.

occasioned by the concussion of the air during the firing of a cannon. The occurrence is generally attended with a loud noise, not unlike that caused by the discharge of a pistol, some hemorrhage, and a good deal of pain. As the edges of the rent retain their contact, the lesion is soon repaired by the interposition of lymph, without any permanent impairment of the hearing.

2. *Inflammation.*—Inflammation of the membrane of the tympanum may arise from various causes, as exposure to cold, external injury, or the presence of a foreign body. It is a frequent sequel of measles, scarlatina, and smallpox, and is often directly dependent for its origin upon a strumous state of the system. Infants and young children are most prone to its attacks, especially such as are naturally of a delicate constitution, or who have suffered from poverty and want. When this is the case, it is often induced by the most trifling causes, and followed by the most disastrous consequences, such as partial destruction of the membrane and partial or complete deafness.

Upon examining the inflamed membrane with the aid of a strong light, it will be found to exhibit a pale rose color, which, as the morbid action advances, is generally converted into a deeper hue. Small, straggling vessels are seen ramifying over the affected surface, and the part, instead of being thin and transparent, as in the natural state, is thick and opaque, from interstitial deposits. The inflammation often affects the adjoining parts, especially the bottom of the auditory tube, and, when this is the case, there is also apt to be an increase of cerumen, soon followed by suppuration or a discharge of muco-purulent matter.

Tympanitis is characterized by the existence of more or less pain, situated deep in the ear, and extending to the side of the head; it is generally described by the patient as exceedingly sharp, aching, and distressing, and is always aggravated by loud noise, stooping, coughing, or sneezing, and by exposure of the part to the cold air. As the disease approaches the suppurative point, the pain generally becomes throbbing, and almost agonizing, depriving the individual both of appetite and sleep. The parts around are now more or less tender, and the movements of the jaw add greatly to the local distress. The sense of hearing is usually considerably exalted; loud, cracking, or ringing sounds are perceived, and there is often a feeling of fluttering as if an insect were flying about in the ear. The inflammation, if at all severe, is attended with high symptomatic disorder, and occasionally with delirium.

In the treatment of acute tympanitis active antiphlogistic measures should be employed with the least possible delay, with the twofold object of saving structure and preventing cerebral involvement, the two great dangers in every severe attack of this kind. If the pulse is strong and full, the pain excessive, the mind delirious, and the skin hot and dry, blood must be taken freely from the arm, the operation being followed by the application of leeches over the mastoid process, a brisk purgative, the hot foot-bath and the antimonial and saline mixture, with a sufficiency of morphia to relieve suffering and induce sleep. Copious diaphoresis should be aimed at, and promoted by tepid drinks. The steam of hot water, directed upon the ear and the adjacent parts by means of a funnel inverted over a large pitcher, will often

prove exceedingly grateful, and afford more decided comfort than almost anything else. Its efficacy may be greatly enhanced by the addition of laudanum and powdered camphor, or camphor dissolved in alcohol. Covering the parts with a large emollient poultice, or hot cloths, will also be productive of great amelioration. The patient's head should be constantly maintained in an elevated position, noise should be excluded from the apartment, and the surrounding temperature should be regulated with the thermometer, especially in cold weather. If cerebral involvement be threatened, leeching and counter-irritation will be necessary. In the event of there being any discharge, the syringe and tepid water may be had recourse to, but it is impossible to be too careful in their use, otherwise they will be sure to aggravate the disease instead of diminishing it. As to any direct application, the only one at all admissible, as a general rule, consists of equal parts of laudanum and glycerine, slightly warmed, and introduced into the bottom of the ear, in immediate contact with the affected surface. Irritating lotions always prove prejudicial, and cannot be too much condemned.

3. *Abscess and Gangrene.*—Inflammation of the membrane of the tympanum probably terminates much more frequently in the formation of abscess than practitioners are aware; but, owing to the difficulty of examining the parts when thus affected, the occurrence commonly escapes detection. The pus is seated in the submucous cellular tissue, and, although very small in quantity, generally leads to perforation of the membrane, and the discharge of the small bones of the ear, its formation being ordinarily preceded by rigors and delirium. The treatment is antiphlogistic. If the abscess is accessible, evacuation is effected with a cataract needle, and cicatrization promoted by the cautious application of nitrate of silver, upon the extremity of a probe.

Of gangrene of the membrane of the tympanum little is known. Such an event is doubtless possible, and probably occurs not unfrequently, especially in scrofulous subjects, as a consequence of eruptive disease. If this were not so, how could we explain the extensive destruction of this membrane which occasionally takes place within a few days after the establishment of inflammation, the occurrence of necrosis in the temporal bone, and the almost insupportably fetid discharge which attends certain diseases of the ear?

4. *Ulceration and Otorrhœa.*—Ulceration of the membrane of the tympanum may be an effect of ordinary inflammation, both acute and chronic; or it may be caused by a strumous or syphilitic taint of the system, most generally the former. The erosive action may display itself in the form of little, superficial abrasions, not larger, perhaps, than a small pin-head, and of a circular or oval shape; or in that of a deep and broad surface, with abrupt and well-defined edges, rapidly followed by perforation of the effected part, and the discharge of some of the bones of the ear. The ulceration often proceeds until the whole membrane is destroyed, and all the adjacent parts, osseous as well as soft, are involved in the mischief. In such cases the morbid action sometimes extends to the substance of the temporal bone, and thence along to the brain and its meninges, leading to various effusions and the formation of abscesses, from which the patient seldom, if ever, recovers. In some cases there is, in addition to these affections, facial paralysis, from involvement of the portio dura, in consequence of the propagation of the ulceration through the aqueduct of Fallopius.

Most cases of this disease that are not produced by mechanical causes are of a strumous nature. The subjects are generally young, delicate children, who are either the offspring of persons who have perished from phthisis or from some allied disease, or who are themselves destined to suffer in this way. The exciting cause of the complaint is either exposure to cold or an attack of measles, scarlatina, or some other eruptive disease, the tendency of which is to impoverish the blood and exhaust the vital powers. The ulceration is frequently of a very insidious character, coming on without any pain during the convalescent stage of the cutaneous malady, and continuing, with, perhaps, little intermission, for an almost interminable period. Cases of this kind are often met with which have lasted for five, ten, and even fifteen years. The discharge is generally of a thick, cream-like consistence, of a yellowish color, verging upon greenish, and so horribly fetid as to render the patient disagreeable both to himself and to those around him. Exposure to cold, derangement of the digestive organs, and neglect of cleanliness, always aggravate it. It is often attended with fungous or polypoid growths, and is liable, unless closely watched,

to be followed by inflammation of the brain and its membranes. A sudden suppression of such a discharge, especially if accompanied by severe headache, should always be regarded with suspicion.

When the ulceration, by whatever cause induced, is of long standing, or of considerable extent, deafness, more or less complete, is the inevitable consequence. All, therefore, that can be done in such a case is to endeavor to arrest the disease, and happy is the surgeon who can succeed in his efforts; for it may truly be asserted that there is no affection which is more unmanageable, or more difficult to be brought under the influence of remedies. As to any improvement of the hearing, that is hardly to be thought of. It is only when the disease is slight, and the constitution has not been impaired by previous suffering, that this is to be looked for. The practitioner, indeed, cannot be too guarded in his prognosis. He should do all he can, but promise nothing.

Persons laboring under the more aggravated forms of this disease occasionally perish from an extension of the morbid action to the petrous bone, or to this bone and the brain and its envelops. The danger is always greatest in very young children, in whom this bone consists almost entirely of diploë, or of a soft, spongy structure inlaid with veins. In some cases, secondary phlebitis arises, apparently from an extension of the disease along the cerebral sinuses and internal jugular veins. The parts most liable to suffer in this manner are the lungs, pleura, liver, and joints. The symptoms announcing these events are such as ordinarily usher in the occurrence of pyemia. The most prominent are rigors, or chilly sensations, alternating with flushes of heat, and rapid exhaustion of the vital powers, with excessive restlessness and a tendency to low muttering delirium, especially when there is serious involvement of the brain. In the latter case, there will also be violent cephalalgia, and agonizing pain in the affected side of the head.

Involvement of the internal carotid artery is occasionally observed in the more severe forms of these affections, the more common alterations being inflammation of its tunics, and occlusion of its interior, by fibrinous concretions, followed, now and then, by perforation and fatal hemorrhage, the blood escaping by the external meatus or by the Eustachian tube. A similar occurrence is occasionally met with in the jugular vein. A number of cases have come under my observation of facial paralysis from inflammation and compression of the portio dura, caused by caries of the petrous portion of the temporal bone.

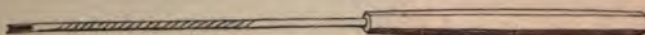
The *treatment* of ulceration of the membrane of the tympanum is too frequently conducted empirically. When the disease has been induced by the presence of a foreign body, or by the retention of pus from some morbid growth, the removal of the exciting cause will often of itself be sufficient to effect a cure; but where no positive information exists respecting this point, our course must, necessarily, be one of uncertainty. A careful examination should always be made of the condition of the parts before we begin the treatment, by washing out the ear with tepid water, thrown in gently with a large syringe. The prominent indications are, first, to allay fetor, and, secondly, to arrest the morbid action. The former is fulfilled by the free but cautious use of deodorizers, as chlorinated soda, or permanganate of potassa, injected into the ear twice or thrice in the twenty-four hours; the latter, by counter-irritation, the topical application of nitrate of silver, chloride of zinc, or yellow-wash, and by attention to the state of the system.

When the disease is of a strumous nature, or associated with debility, an alterant and tonic course will be indicated, consisting of iodide of iron and extract of cinchona, alternated with cod-liver oil, and combined with nutritious diet and exercise in the open air. The surface should be well protected, and sponged daily with tepid salt water, followed by dry friction. Too much attention cannot be bestowed upon cleanliness; for, apart from the offensive character of the discharge, the accumulation of pus in the ear must necessarily tend to keep up the morbid action, and to increase the mischief. Nitrate of silver, although undoubtedly one of the very best topical remedies, should not be employed without the greatest caution. A solution of five to ten grains, applied once a day, with a short, stiff camel-hair pencil, after the ear has been thoroughly cleansed with tepid water, is a good average strength, generally well borne, and followed by rapid amendment. A weak solution of chloride of zinc is also an excellent preparation. In many cases, I have derived marked benefit from the use of yellow-wash, in the proportion of one-eighth to half a grain of bichloride of mercury to the ounce of lime water. Glycerine and tannic acid, sulphate

of copper, and iodide of iron may be mentioned as among the better and more reliable subordinate articles.

Solid nitrate of silver may sometimes be advantageously employed in this affection, but it must be applied with extreme caution, otherwise it will inevitably do mischief. Perhaps the best instrument for the purpose is that of Wilde, sketched in fig. 250. It consists of a silver tube, six inches long, cut spirally for about three-

Fig. 250.



Wilde's Port-caustic.

fifths of its length, and having an aperture in the side, or a hollow at the end, filled with the salt melted over a spirit-lamp. The elastic spring may be bent to any point, and is so yielding as to prevent injury to the ear from the starting of the patient. The caustic should be brought in contact only with the edges of the ulcer, by the lightest possible touch, the application being repeated, at first, once every other day, and then twice a week.

Whatever the applications may be, care must be taken not to let the discharge dry up too rapidly, lest disease should be excited in the brain and its membranes. This precaution is particularly necessary in cases of long standing, accompanied with extensive disorganization of the structures of the ear. To obviate this occurrence, and at the same time aid in arresting the ulcerative action, an issue with the actual cautery should be established behind the ear, over the mastoid process, and kept open for a long time after all disease has apparently vanished. When symptoms of cerebral involvement arise, they must be promptly met by leeches, blisters, and such other means as will readily suggest themselves in a case of such emergency.

When the origin of the disease is due to a syphilitic taint of the system, it will be necessary, in addition to the local means here pointed out, to place the patient upon the use of iodide of potassium, either alone or in conjunction with bichloride of mercury, in small doses, continued sufficiently long to produce slight ptyalism.

To the disease now described, the term *otorrhœa* is usually applied; and practitioners, in prescribing for it, unfortunately too often forget that the concomitant discharge is merely a symptom of the affection, and not the disease itself. Another mistake that is often committed is the belief that the affection upon which the discharge depends will in time disappear spontaneously, or, to use a common expression, that the patient, especially if a child, will gradually outgrow it. Such an opinion is as absurd as it is culpable, and cannot be too severely censured. The poor patient, confiding in the judgment of his professional adviser, goes on from bad to worse, until, awakening from his dream, he finds that his ear is completely disorganized, and that he is irremediably deaf. Such cases are of constant occurrence; and, while they are calculated to excite our sympathy for the sufferer, they cannot fail to rouse our indignation at the surgeon, who, either through ignorance, indolence, or supineness, neglects to make himself acquainted with the true nature and treatment of the disease.

SECT. IV.—INFLAMMATION OF THE CAVITY OF THE TYMPANUM.

This disease, which has been variously designated by aural surgeons, the terms being nearly all more or less objectionable, is seated in the lining membrane of the middle ear, which is continuous, along the Eustachian tube, with that of the fauces. As it progresses, it may invade other structures, as the fibrous layer of the tympanum, and even the labyrinth; or, beginning in these, it may extend to and involve the mucous tissue secondarily. Unfortunately, our knowledge of the maladies of these delicate parts of the organ of hearing is too limited to enable us to speak very positively upon the subject; their deep situation, the difficulty of exposing them, and the infrequency of their fatality, being so many reasons of the imperfection of our information. Inflammation here is probably more common than is generally imagined, and it is not at all unlikely that some of the fatal cases of disease of the base of the brain, which are met with from time to time, have their seat originally in the middle and internal ear.

The causes of this disease are usually very obscure, although, in very many cases, it is directly traceable to the effects of cold, or suppression of the cutaneous perspiration. It may also be induced by external injury, by the presence of a foreign body, by irritating applications to the membrane of the tympanum, and by an extension of inflammation from the tonsils and fauces along the Eustachian tube. Children and young persons are its most common subjects, especially such as are of a strumous predisposition. Occasionally the disease is caused by a marked syphilitic taint of the system.

The relation of inflammation of the cavity of the tympanum to the exanthematous diseases, especially measles and scarlatina, has been placed in a very striking light by the observations of Wilde, Tröltsch, Clark, Pomroy, and other writers. A very considerable proportion of the cases of non-congenital muteness are due to the effects of these eruptive fevers. Of 1892 cases of acquired deafness, from all causes, occurring in Belgium, 216 arose from scarlatina, 80 from measles, and 28 from smallpox. The inflammation, under such circumstances, begins in the throat, from which it extends along the Eustachian tube to the middle ear, occasioning thickening of the lining membrane of the canal, and effusion into the cavity of the tympanum, not unfrequently followed by ulceration and perforation of the drum of the ear, copious fetid discharge from the auditory meatus, and more or less impairment, if not complete destruction, of the function of audition.

The affection is ushered in by pain in the ear, which is speedily followed by fever, alternating with rigors. The pain is deep-seated, and, rapidly increasing, soon amounts to intense agony, being of a tearing, boring, dragging, or pulsatile character; it is aggravated by the slightest motion of the head, and darts about in different directions, as the temple, forehead, mastoid process, and teeth, which often ache most violently. Cephalalgia is generally present from the beginning, and is soon succeeded by delirium; the patient is unable to remain for a moment in the same posture, and is harassed with all kinds of noises, while the sense of hearing is in the highest possible state of exaltation; the countenance is flushed, the eyes are suffused, and there is a wildness of expression indicative of the most intense suffering. In the worst forms of the affection, the pain extends along the Eustachian tube into the throat; the whole side of the head is exquisitely tender; the fever increases in intensity; coma at length sets in; and the patient expires under all the symptoms of disease of the brain and its membranes. In some cases, there is facial paralysis, from involvement of the portio dura in the aqueduct of Fallopius. Upon dissection, matter is found in the cavity of the tympanum, and also, not unfrequently, over the petrous portion of the temporal bone, with effusion of serum into the arachnoid sac. In protracted cases, the temporal bone is carious, or partially necrosed, and separated from the dura mater by a distinct abscess. When the patient survives, the matter is sometimes suddenly discharged through the external ear, followed by partial relief of the frightful suffering. The mitigation thus produced, however, is often only temporary, death being caused afterwards either by exhaustion, or, as more generally happens, by inflammation of the brain and its envelops. The period at which this event occurs varies from eight or ten days to several months. In the latter case, the patient is assailed by hectic irritation; he becomes weak and emaciated; his countenance exhibits a sallow, cadaverous appearance; there is profuse discharge from the ear, or from the ear and the Eustachian tube; and the mind is feeble, incoherent, or fatuous.

In regard to the *diagnosis* there is hardly a symptom that is at all worthy of reliance. Perhaps the most important is the violence of the pain, the depth at which it is situated, its unremitting character, and its association with fever, rigors, and delirium. If the patient be a child, the head will be in constant motion, and the hand incessantly carried to the ear: an adult will express himself as being in great torture. The general excitement is higher than in external otitis, the ear is more intolerant of sound, and there is always marked delirium, usually beginning early, and lasting until the malady disappears or proves fatal. Another point of distinction of some value is that matter forms much later than in inflammation of the membrane of the tympanum, or of this structure and of the auditory tube, in which suppuration generally takes place in from twenty-four to forty-eight hours. Finally, there is more tenderness in the mastoid and temporal regions than in external otitis, and more pain in moving the head, sneezing, coughing, and mastication.

The *treatment* of internal otitis must be prompt and vigorous; for, as the disease

is one of great danger both to the part and the system, no time should be lost in timidity and indecision. The most trustworthy remedies are general and topical bleeding, active purgation, the free use of antimonial and saline preparations, the hot foot-bath, Dover's powder, and anodynes in doses sufficient to relieve pain and promote sleep. The best direct application is the steam of hot water, strongly impregnated with laudanum, tincture of aconite, and powdered camphor, and conducted to the ear by means of an inverted funnel, the head being well covered with a blanket during the operation. One great aim of the treatment should be to bring about early and copious diaphoresis, experience having shown that nothing exerts so powerful an influence, after proper depletion has been practised, over the morbid action. Noise is carefully excluded from the apartment, and the body steadily maintained in the semierect posture. As soon as the system has been sufficiently reduced, counter-irritation should be established over the mastoid process, and also, especially if the brain is likely to be involved, in the nape of the neck, at first by means of blisters, and afterwards by issue, croton oil, or tartar emetic ointment. If structural lesion is dreaded, mercury should be given in full doses, with a view to its speedy constitutional effects. If matter form in the middle ear, as denoted by the convex and opaque appearance of the membrane of the tympanum, a puncture should be made to serve as an outlet to the pent-up fluid, its escape along the Eustachian tube being generally prevented by adhesive inflammation. If prompt relief is not obtained in this way, a small opening should at once be made into the mastoid process, especially if there is reason to believe, from the inflamed, swollen, and tender condition of the overlying structures, that its cellular texture participates in the disease.

When the affection assumes the chronic form, the chief reliance must be upon tonics, light but nutritious diet, pyogenic counter-irritation, and the internal use of minute doses of mercury, with a view to slight but persistent ptyalism. The patient is carefully watched, and every precaution taken to protect the brain and prevent relapse.

SECT. V.—DISEASES OF THE INTERNAL EAR.

NERVOUS DEAFNESS.

There is a form of deafness to which, for the want of a better expression, the term nervous is applied. The symptoms which characterize it have long been well understood, but as it respects its pathology we are still, in great degree, in conjecture. It resembles, in many of its essential features, amaurosis. It was, for a long time, attributed to paralysis of the auditory nerve, as amaurosis was attributed to paralysis of the optic nerve. That such an occurrence is possible is undeniable, but that much more importance has been ascribed to it than it is entitled to is equally true. Indeed, there is reason to believe that, in the great majority of cases of what is called nervous deafness, the disease, instead of being caused by a want of power in the nerve of hearing, as a primary lesion, depends wholly upon inflammation. This has certainly been ascertained to be the fact in regard to amaurosis, and that the same circumstance obtains in relation to nervous deafness is now generally admitted. Too much stress cannot be laid upon this view, when we consider the influence which it must exert upon the treatment of this class of affections. Under the supposition that it was, from first to last, a purely nervous disease, the most erroneous practice was pursued, and this is, perhaps, one reason, among many others, why aural maladies have been so long a specialty in the hands of the empirics.

Of the exciting causes of this form of deafness there is no very reliable information. In many of the cases that I have been consulted about, the disease appeared spontaneously, without the patient being able to assign any reason whatever for its occurrence. Occasionally I have known it to come on soon after an attack of typhoid fever, attended with an unusually tardy convalescence. Measles and scarlet fever are also sometimes followed by it. Several of the worst cases of nervous deafness that I have ever seen occurred, apparently, from bathing in cold water, after the body had been overheated by exercise. Profuse and long-continued diarrhœa, protracted hemorrhages, the inordinate use of purgatives, excessive smoking and chewing, masturbation, and abuse of sexual intercourse, have often been known to induce the affection. Another cause, and one which, according to my experience, is more than commonly operative, is chronic dyspepsia, so rife among the people of this country.

The disease generally begins in one ear, and, after continuing for some time, attacks the other; or it may be confined to one ear exclusively; or, lastly, it may commence simultaneously on both sides, and proceed uniformly or otherwise, until audition is completely lost. Sometimes it is produced very suddenly. Not long ago, I saw a child, four years old, who went to bed perfectly well in the evening, and woke up completely deaf in the morning. Great fright, and the concussion occasioned by the firing of a cannon or even a pistol, have been known to deprive persons instantaneously of the faculty of hearing.

Nervous deafness is sometimes hereditary, as in a case which came under my observation in a young man, twenty-one years of age, who was partially deaf in his right ear, evidently from an affection of the auditory nerve; the disease had been coming on gradually for eighteen months, and was attended with great buzzing, as well as other disagreeable noises, and occasional headache. He had never had typhoid fever, measles, scarlatina, or smallpox. He was one of nine children. His eldest brother, thirty-five years of age, was very deaf in both ears; a sister, aged thirty, suffered in one. The father was deaf in both ears, and so was a paternal aunt. The paternal grandfather was likewise deaf. The mother heard well. A similar case has been reported to me by Dr. G. R. Patton, of Cincinnati, in which the deafness has manifested itself in four generations, chiefly in the male branches of the family.

The first intimation which the patient usually has of his infirmity is, perhaps, derived from his friends, who, in their intercourse with him, are rendered conscious that he does not hear so well as formerly. They are obliged, in addressing him, to repeat their questions or answers more frequently, and to speak in a louder tone and more emphatic manner. Along with this occurrence there are various noises in the ears, at first slight and occasional, but gradually becoming more and more intense and steady, until, in time, they constitute the great and absorbing symptom. Of the character of these noises it is difficult to convey any accurate idea. Most commonly, however, they are of a tinkling, ringing, roaring, or buzzing nature. Usually confined to the ears, they are sometimes perceived over the greater part of the head, and are liable to be aggravated by fatigue, exposure, atmospheric vicissitudes, dyspepsia, constipation of the bowels, and, in short, by whatever has a tendency to derange the general health, or to depress the vital powers. If occasionally slight amelioration occurs in the patient's condition, it is always very transient, lasting seldom more than a few hours, or, at most, a few days. During this period the hearing is not only improved, but there is a considerable diminution of sound, and illusive hopes are entertained of speedy recovery. Presently, however, the symptoms recur in all their former intensity, and the disease goes on rapidly from bad to worse until the deafness is complete.

There are cases of this affection in which there is an entire absence of noise. They generally come on very suddenly, in consequence often of some disorder of the brain, and are of the most hopeless character as it respects recovery. It is probable that this variety of the disease is due to paralysis of the auditory nerve.

Nervous deafness is seldom attended with any pain in the ear or the surrounding parts. The patient, in addition to the noises already described, often complains of a sense of fullness in the organ, or a feeling as if the auditory tube had been stopped up with water; but, as to actual pain, he does not experience any, except occasionally as an intercurrent and adventitious circumstance. The general health is variable. In many cases it is impaired, perhaps very materially, at the moment of the attack; but in some it is, apparently, as perfect and vigorous as it ever was. Some of the very worst examples of nervous deafness that I have ever witnessed occurred in persons of this description. The period which intervenes between the commencement of the first symptoms and the occurrence of complete deafness varies from a few weeks to a number of years. Occasionally the individual is able to hear more or less all his life, especially if he uses an ear-trumpet.

The ear, in nervous deafness, often retains its normal appearance most perfectly. The secretion of cerumen proceeds as before, and there is not the slightest evidence of disease in the membrane of the tympanum. Sometimes, however, there is a total absence of wax, and then the drum is not only unusually dry, but more or less opaque. When touched with a probe, it is often found to be remarkably sensitive, as is the case also frequently with the parts immediately around.

Among the numerous remedies that have been recommended for the relief of

nervous deafness, there is not one which is worthy of the slightest reliance in a curative point of view. I have myself so seldom derived any benefit from them that I have long been induced to look upon the disease as being generally incurable. Whatever advantage results is usually of a transient character, due, in great measure, if not wholly, to the effects which the treatment exerts upon the condition of the general health rather than to any improvement in the ear itself. The misfortune is that, in most cases, the affection is entirely neglected in its earlier stages, at a time when medication might, perhaps, be of service. The patient, thinking that it is a matter of little moment, or that it will gradually vanish of its own accord, feels little inclined to apply for advice, until it is generally too late to do him any good. When the disease supervenes suddenly, and in its more decided forms, I believe that no remedies, however judiciously employed, will be of any avail. All experience goes to show that such cases are generally hopeless. Under opposite circumstances, however, it is always proper to institute as rational a course of proceeding as our limited powers of observation will admit. Looking upon the disease as being commonly of an inflammatory origin, and, therefore, as likely to produce structural disorder, the best plan that can usually be adopted is to put the patient upon a very mild course of mercury, giving from a fourth to half a grain of calomel three times a day, until there is slight soreness of the gums, which should then be diligently maintained for a number of consecutive weeks, without any risk of salivation. If plethora exist, recourse may be had to active purgation, leeching behind the ears, and even general bleeding, along with light diet, and a large issue in the neck; or, what is better, a small one over each mastoid process. If, on the other hand, there is evidence of general debility, as happens in a plurality of such cases, the mercury must be combined with tonics, as iron and quinine, a nutritious diet, the shower-bath, and daily exercise in the open air, with saline ablutions and dry frictions. I place great confidence in the use of mercury in this disease, particularly in its earlier stages, from its salutary effect in preventing structural change. When the lesion is fully established, no benefit need be anticipated from its employment.

In regard to direct applications, it is impossible to observe too much precaution. When there is opacity of the membrane of the tympanum, the affected surface may be gently touched, once a day, with a little dilute mercurial ointment, or a solution of nitrate of silver, in the proportion of five to ten grains of the salt to the ounce of water. Another appropriate remedy is glycerine with a small quantity of spirit of camphor. Whatever substance be employed, care must be taken that it acts merely as a sorbefacient, and not as an irritant; otherwise serious mischief may ensue.

The treatment of nervous deafness by the introduction of the vapor of nitrous ether into the cavity of the tympanum, through the Eustachian tube, is, I believe, no longer employed, notwithstanding the high encomiums that were formerly lavished upon it by Kramer and other professed aurists. From personal experience with the remedy I was led, long ago, to regard it as one of the delusions of surgical practice; a conclusion fully verified by the later observation of others. Of faradization and galvanization, as means of relieving nervous deafness, nothing need be said here, as experience has shown that they are of no benefit.

DEAFNESS FROM DISEASE OF THE TYMPANUM AND OTHER CAUSES.

Besides this form of deafness now described there are others, some of which are transient and curable, others permanent and irremediable. In order to appreciate their character, it will be necessary briefly to inquire into their causes. These will be found to be both numerous and diversified.

1. Deafness is often produced by destruction of the membrane of the tympanum, either as an effect of ulceration, of a wound, or of the contact of some acid, introduced by design or from mischief. When the lesion is considerable, it is necessarily accompanied by the loss of the small bones, and by the annihilation of the sense of hearing. Injuries of the skull and brain are occasionally followed by deafness, sometimes partial, at other times complete. This effect is most liable to supervene upon injuries of the base of the cranium, especially such as are attended with fracture of the petrous portion of the temporal bone and laceration of the meninges of the brain; but it may also take place when the lesion is seated upon the side and top of the skull, and when it is apparently of a more trivial character. A severe box

upon the ear or temple has been known to cause permanent deafness, probably by rupture of the membrane of the tympanum.

2. Mere concussion of the membrane of the tympanum sometimes produces deafness. Several cases have come under my notice where it was caused by the discharge of a cannon, a gun, or even a pistol. Artillerymen are occasionally, in an instant, deprived of the faculty of hearing during the progress of a battle, or the firing of a salute, from the sudden and violent agitation of the air. Under such circumstances, indeed, it is not uncommon to observe a considerable flow of blood from the ear.

3. Caries and necrosis of the temporal bone are a frequent source of deafness. The same effect may be induced by the pressure of a tumor upon the nerve of the ear, the long retention of hardened wax, the pressure of a foreign body upon the membrane of the tympanum, the deposit of lymph or tubercular matter in the middle cavity of the ear, and occlusion of the Eustachian tube.

4. Violent sneezing and coughing have been known to produce deafness. Of the possibility of such an occurrence there can be no question, as a number of well-authenticated cases of it are upon record. Forcible inflation of the Eustachian tube may lead to a similar result, the immediate cause in all these instances being rupture of the membrane of the tympanum.

5. Another cause of deafness is frequent washing of the head in cold water, cutting off the hair very close in cold weather, or exposing the head, especially when the body is overheated, to currents of cold air.

6. The inordinate use of quinine has occasionally been followed by complete and irremediable deafness in a few hours. Of this occurrence numerous cases are to be found among the inhabitants of our Southern States, where this article is often given in enormous doses.

7. Deafness is sometimes produced by worms in the alimentary canal, the repulsion of cutaneous disease, and the suppression of habitual discharges. Lauzani mentions the case of a woman who suffered from deafness during four successive pregnancies.

8. Loss of hearing may be occasioned by effusions at the base of the brain, whether the result of external injury, tuberculosis, or common inflammation, leading to compression of the cerebral tissues, or, directly, of the auditory nerve itself.

9. Deafness is sometimes dependent upon malformation or disease of the internal ear. Cases occur in which there is no trace whatever of the vestibule, cochlea, and semicircular canals. Occasionally the labyrinth is composed of a single cavity, shut off entirely from the tympanum, as in the crustaceous animals. Finally, the internal ear is sometimes occupied by scrofulous matter, serum, fibrin, or a substance resembling chalk.

10. The cause of deafness may reside in the cavity of the tympanum, which may be filled up with various kinds of materials, as mucus, lymph, pus, and blood, interfering with the transmission of sound. A substance resembling tubercle, and consisting of granules, epithelium, and oil globules, has been found in this portion of the ear, the occurrence being most common in young subjects of a scrofulous predisposition. Finally, the cavity of the tympanum may be absent; or there may be an imperfect development of the small bones of the ear.

11. Deafness is sometimes, perhaps not unfrequently, produced by abnormal tension of the drum of the ear dependent upon the inordinate contraction of its tensor muscle. When this is the case, the lesion is almost invariably associated with various distressing noises in the ears, and also, in many cases, with giddiness and other unpleasant head symptoms.

12. Necrosis of the bony structures of the internal ear is necessarily followed by complete destruction of the function of audition. In the case from which the annexed cut, fig. 251, was copied, the necrosis involved the whole of the cochlea, vestibule, and semicircular canals, and gave rise to the most violent inflammation of the brain, with paralysis of the face, arm, and leg, and total deafness on one side.

Fig. 251.



Necrosis of the Internal Ear.

13. There may be lesion of the auditory nerve, consisting either in imperfect development, interstitial deposits, induration, softening, paralysis, or compression by osseous and other matter. Deafness, seated in the nervous structures of the ear, is not very uncommon in hereditary syphilis.

14. Deafness may be occasioned by lesion of the mastoid process, the cells of which are lined by a reflection of the mucous membrane of the middle

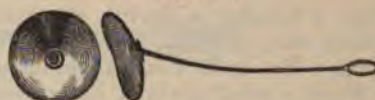
ear, and which are, therefore, liable to the same kind of diseases. Inflammation, whether traumatic or idiopathic, may lead to various changes in this supplemental portion of the ear, all more or less prejudicial to audition. It is also liable to malformations, obliteration, and scrofulous deposits.

15. Finally, deafness, partial or complete, may be caused by enlargement of the tonsils, by polyps of the nose, and by various affections of the fauces, leading to obstruction of the Eustachian tube, and to changes of structure in the middle ear. Cases have come under my observation in which inflammation, caused by a common cold, spread along the Eustachian tube from the Schneiderian membrane, without any participation of the lining membrane of the throat in the morbid action.

It is not necessary to enter into any formal account respecting the *treatment* of these various kinds of deafness. Their chief interest consists in their diversity, and the consequent necessity of inquiry into their character before an attempt at their removal is made by the use of remedies. Some of them, from their very nature, are incurable; others, for the same reason, hold out a prospect of relief by judicious treatment; and a few will disappear spontaneously, or simply by the operation of time. Deafness caused by inordinate tension of the membrane of the tympanum may occasionally be remedied by the division of its tensor muscle, an operation described further on.

When the deafness depends upon the loss of the drum of the ear, the hearing may often be greatly improved by an artificial substitute, fig. 252, consisting of a circular or oval piece of very thin India-rubber, as originally suggested by Mr. Toynbee. It is attached to a very delicate wire rod, a little more than an inch in length, and may be very easily introduced and withdrawn by the patient himself. It should be worn at first for a few hours only a day, and then not in contact with the remnants of the tympanic membrane, lest it should occasion irritation. It is always removed at night, and the ear syringed twice a day if there is any discharge. When no such contrivance is at hand, great comfort and advantage will be derived from the use of a little pellet of cotton-wool, moistened with glycerine, and inserted into the ear, in contact with the aperture at its bottom. Substitution may be effected several times, daily, according to the amount of discharge.

Fig. 252.



Toynbee's Artificial Tympanic Membrane.

SECT. VI.—DISEASES OF THE EUSTACHIAN TUBE.

The Eustachian tube, which establishes a direct communication between the middle ear and the fauces, is liable to various affections, which influence, to a greater or less extent, the function of audition. These affections may be thus enumerated: 1. Congenital occlusion. 2. Inflammation. 3. Mechanical obstruction. 4. Stricture.

1. Congenital *occlusion* of the Eustachian tube is probably more frequent than is generally imagined. It is similar to the malformation which is met with in some of the other mucous outlets of the body, as the anus, urethra, and vagina, and may affect the entire canal, or be limited to a particular portion. In the latter case, the obstruction is caused either by a small membrane, not unlike a hymen, or by the presence of fibrous, fibro-cartilaginous, or cartilaginous tissue. However induced, it is generally, if not always, a cause of deaf-dumbness, and is beyond the reach of relief.

2. The Eustachian tube, being lined by a reflection of the mucous membrane of the fauces, is liable to *inflammation* and its various consequences, as thickening, ulceration, and even gangrene. Scrofulous children, affected with chronic disease of the tonsils, are particularly prone to suffer in this way. The inflammation of the fauces often continues for years, being constantly subject to exacerbations from the slightest exposure to cold, derangement of the digestive organs, and whatever has a tendency to excite and maintain general debility. The membrane, from this habitual congestion, becomes gradually indurated and thickened from interstitial deposits, and thus ultimately encroaches very seriously upon the caliber of the tube. Similar effects are often produced in inflammation of the throat consequent upon some of the eruptive diseases, particularly measles, scarlatina, and smallpox. The morbid action thus awakened not unfrequently extends into the Eustachian tube, and thence along

the tympanum, where, leading to various deposits and alterations of structure, it may be followed by the worst results.

Ulceration of the Eustachian tube is observed chiefly in connection with constitutional syphilis, attended with destruction of the tonsils and the arches of the palate. Under such circumstances, the membranous portion of the canal may be entirely eroded, followed, during the healing process, by occlusion of the remainder of the passage. Gangrene of the tube is extremely rare.

Inflammation of the Eustachian tube may lead to a deposit of *plastic* matter, which, when the quantity is considerable, may cause permanent closure of the tube. Of suppuration of this passage very little is known, but the probability is that it is much more common than is usually imagined.

3. *Mechanical obstruction* of the tube may arise from the presence of inspissated mucus, fibrin, blood, and earthy matter.

Inordinate secretion of mucus is an occasional occurrence in this tube, chiefly as a consequence of chronic inflammation. When the fluid is very thick, or long retained, it may completely clog up the passage, and thus seriously impair hearing. Such an occurrence will be most likely to happen when the mucus is intermixed with plastic matter. A clot of blood, the result of hemorrhage in the internal ear, may be a source of obstruction.

Finally, a substance resembling chalk—probably nothing but altered tubercular matter—is sometimes found in the Eustachian tube, closing it either partially or completely, and thus acting as a cause of deafness.

A foreign body introduced from without is occasionally met with in this canal, as when a substance, during attempts at extraction, is accidentally pushed into the middle ear, or when, from long retention, it causes perforative ulceration of the drum. The most remarkable instance upon record is one related by Fleischmann, in which a small grain of barley was found projecting from the naso-pharyngeal orifice. The only inconvenience produced by it was an annoying noise in the corresponding ear.

4. *Stricture* of the Eustachian canal is uncommon. It generally appears as a small, narrow band, stretched across the tube from one side to the other; or as a ring-like contraction; or, when it involves the osseous part of the canal, as a species of exostosis, growing inwardly and filling up the conduit. Sometimes the passage is obliterated nearly from one extremity to the other. However constituted, the obstruction is usually permanent, although it may not be complete.

The faucial orifice of the tube is sometimes occluded by the adhesion of the palate to the back and sides of the pharynx, as a consequence of syphilitic disease. Partial closure sometimes occurs in cleft palate, from the pressure of the divided soft parts.

5. The *diagnosis* of the various affections of the Eustachian tube above described can only be established by means of the catheter, all other attempts at arriving at a knowledge of them being useless. It was formerly imagined that the existence of obstruction, from whatever cause arising, could readily be determined simply by inflation, during a forced expiration, by shutting the mouth and holding the nose; it being asserted that if the air did not penetrate the tube, it was an evidence that it was closed. Nothing, however, can be more erroneous; for there are, as is well known, many persons who cannot, by any effort they can employ, distend this passage at all, however clear it may be. I have myself never been able to blow air into my left Eustachian tube, although my hearing is perfect, and the operation always promptly succeeds on the right side. Catheterism, then, is the only reliable means of diagnosis, and it is so much the more valuable, because, while it enables us to obtain important information respecting the nature of the disease, it is one of the best methods of cure. The operation of forcing air into the Eustachian tubes when the mouth and nostrils are closed is generally known as the "experiment" of Valsalva, from the fact that it was first distinctly described by that celebrated pathologist. Although, as previously stated, it is uncertain as a means of diagnosis, it is often of great service in freeing these passages from accumulations of mucus consequent upon acute and chronic inflammation.

The existence of inflammation may be suspected when, along with inflammation of the fauces or nose, there are more or less pain in the ear, a sense of weight, pressure, or fullness, defective hearing, and excessive tinnitus, crackling, gurgling, roaring, or buzzing, increased by exposure to cold, recumbency, and loud talking. In speaking, the voice sounds in the patient's ear as if a drum were beating in it. The

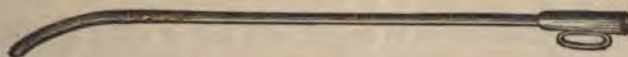
noise is occasionally very loud and sudden, like a crack, apparently from the bursting of an air-bubble. The history of the case and a careful inspection of the throat often furnish important diagnostic information.

Complete deafness of the affected ear does not necessarily follow complete obstruction of the Eustachian tube. The hearing is, of course, more or less impaired; at times, however, it is comparatively good; and cases are met with, although they are uncommon, in which it is temporarily either very much improved or diminished. When the obstruction is of long standing, the tympanum generally participates in the morbid action. Toynbee has found that, under such circumstances, the membrane is very concave, and of a dull, leaden hue, remarkably depressed inwards towards the stapes, or opaque, uneven, and irregular.

6. *Catheterism* of the Eustachian tube is quite as simple an operation as that of the bladder; but as it demands an unusual amount of practice, as well as a most accurate knowledge of the anatomy of the parts, it is evident that it can never come into general use. Besides, it is an operation which requires great delicacy on account of the exquisite sensibility of the tube, as well as of the surface immediately around. For want of proper care in its performance, serious mischief may be produced.

Different kinds of instruments are in vogue for exploring this canal; some being straight, others curved; some flexible, others inflexible. The one which I have always been in the habit of using is represented in fig. 253. It is composed of

Fig. 253.



Catheter for the Eustachian Tube.

silver, and is, consequently, inflexible, being six inches in length, and having a short curve at its distal extremity, with a very smooth, probe-pointed orifice. It varies in diameter from the size of a crow quill to that of a small goose quill, according to the age of the patient. In its general outline, it is somewhat conical, and the ring at its large extremity corresponds with the concavity of the curve at the smaller one; an arrangement which is found to be useful in the introduction of the instrument, as it indicates the direction of its point.

The patient being seated upon a chair with the head thrown backwards against the breast of an assistant, the catheter, properly oiled and warmed, is inserted into the nose, its concavity being directed downwards towards the floor of the nostril, along which it is conveyed until it reaches the fauces. Its point is now turned upwards and outwards, so that the ring of the instrument shall be in an oblique position, while its body shall lie in close contact with the outer wall of the nasal fossa. All that is required now is to pass the catheter gently on, when it cannot fail to reach the tube, its entrance being denoted by a want of resistance, and a feeling as if it moved in a narrow track. The distance to which it may be carried will depend upon its size and upon the presence or absence of mechanical obstruction. Under no circumstances, unless the instrument is uncommonly small, can it be pushed on into the middle ear.

If now, while the catheter is in position, air be blown through it into the tube, it will be easy to determine, at least in many cases, both the degree and the character of the obstruction. Thus, if the closure is partial, the fluid will readily find its way into the middle ear, very much as when inflation is attempted by shutting the mouth and nose; whereas if it is complete no such effect will follow. The presence of mucus may generally be detected by the peculiar gurgling or rustling sound which the patient perceives as the air rushes past the accumulated fluid; and soon after he will probably be conscious of a diminution of the disagreeable noises which previously disturbed him. If, on the other hand, the obstacle is of a solid nature, the sound produced by the inflation will be indistinct, or similar to what is caused by blowing against a bone or other hard body.

Stricture of the tube, from ordinary inflammation, may be suspected when the point of the instrument, after having passed a certain distance, refuses to advance any farther. It may be inferred that the obstruction is osseous, calcareous, or

sensibility of the tube, so generally present in inflammation. The operation may be repeated, at first, once every fourth day, and afterwards every twenty-four hours, the instrument being retained several minutes each time. It may be assisted by the inflation of air from the operator's mouth, or, after the withdrawal of the catheter, by the patient's own efforts.

Obstruction of the Eustachian tube, from accumulations of mucus, is generally easily relieved by inflation of the canal, as originally suggested, in 1863, by Dr. Politzer, of Vienna, whose apparatus, consisting of an India-rubber bag, provided

Fig. 258.



Poltzer's Bag for Inflating the Eustachian Tube.

with a tube surmounted with a piece of ivory pierced with several small openings, is represented at fig. 258. I much prefer, however, an ordinary gum female syringe, furnished with a suitable nose-plug and a central ball, as it greatly simplifies the operation, inasmuch as the tube is open at both ends. The plug being inserted to the distance of about half an inch into the nose, the mouth and nostrils are closed, and rapid efforts are made at deglutition. It is not necessary, as is generally stated, to hold any water in the mouth to facilitate the process of inflation. Care must be taken not to blow too hard, otherwise rupture of the membrane of the tympanum may occur, as in a case recently under my observation.

When more direct medication is required, the object may be attained by the injection of tepid water, slightly impregnated with some astringent article, as sulphate of zinc or acetate of lead. Great care must be taken that the solution is as mild as possible, otherwise much harm may result. A better remedy than either of these is nitrate of silver, in the proportion of about an eighth of a grain to the ounce of water. Whatever substance

is used, the injection should not, on an average, be repeated oftener than once every third or fourth day.

Along with these means, special attention should be paid to the general health; the diet properly regulated, the bowels maintained in a soluble condition, and a free discharge kept up behind the ear by means of an issue. When the disease is obstinate, and fairly attributable to the effects of inflammation, benefit may be derived from slight and steadily continued ptyalism.

Deafness, caused by permanent occlusion of the Eustachian tube, was formerly treated by perforation of the membrane of the tympanum. The operation, proposed early in the present century by Sir Astley Cooper, was at one time much in vogue, although it is now obsolete. The object was to drill a small opening into the drum, in order to admit air into the middle ear, the absence from which, as was alleged, was the principal cause of the want of hearing. Subsequently, as the aperture thus made was found to have a tendency soon to close, thereby frustrating the intention of the operation, an instrument was devised for cutting out a circular piece of the membrane. I had occasion, early in my professional life, to give this procedure a very fair trial in several instances, but as no benefit whatever resulted, I have not since repeated it; nor can I find any well authenticated case upon record in which it was of any permanent service.

SECT. VII.—AFFECTIONS OF THE MASTOID CELLS.

Disease of the mastoid cells occurs chiefly in young strumous subjects, from attacks of cold, measles, scarlatina, and smallpox. It is rarely met with after the twentieth year, and then mainly as an effect of external violence. Manifesting itself originally as an inflammation of the lining membrane, it may, in its progress, gradually extend to the osseous structures, on the one hand, causing caries, and even necrosis; and, on the other, to the brain and its envelops, eventuating in abscess of the former, and in thickening and effusions of the latter. In the milder varieties of the disease, which is much oftener chronic than acute, there is, generally, simply an opaque, thickened, and vascular state of the lining membrane, with an abnormal secretion of mucus, to which, when the inflammation is more severe, is frequently

superadded a deposit of pus. In the latter case, especially when the matter does not find a ready outlet through the wall of the auditory tube or the tympanic membrane, suppuration is liable to occur in the lateral sinus, in the brain, and in the arachnoid and pia mater, the morbid action being propagated along the veins of the mastoid cells. In children, before the third year, the cerebrum is most prone to suffer from abscess from this cause, owing to the imperfectly developed condition of these cells, and their close proximity to this portion of the cerebral hemisphere; but, at a later period, when these cavities are more fully formed, the mischief is generally seated in the cerebellum and its more immediate investments. This distinction, first clearly pointed out, I believe, by Mr. Toynbee, is practically interesting, and, therefore, worthy of recollection. When the mastoid process becomes involved, the disease, which may ultimately extend to the petrous portion, if not, at times, also to the squamous, may manifest itself simply as caries, or as caries and necrosis, according to the nature and violence of the morbid action.

In the adjoining cut, fig. 259, from Wilde, the whole of the mastoid process, together with a large piece of the petrous portion of the temporal bone, the posterior wall of the middle ear, and one of the semicircular canals, was removed from a child three years old.

The matter which forms in disease of the mastoid cells, whether it be limited to these cells, or found also in the lateral sinus, cerebrum, cerebellum, pia mater, or arachnoid membrane, is either of the nature of ordinary pus, or, as not unfrequently happens, is strictly of a strumous character, and often quite offensive. In the lateral sinus it is frequently associated with clotted blood.

Collections of pus in the mastoid cells either destroy life by cerebral irritation, or by the induction of inflammation and abscess in the brain and its envelops; or, if the patient survives, they may find a partial vent, by ulcerative action, through the auditory tube or tympanic membrane. More rarely, the fluid is discharged externally along an opening in the mastoid process. Death occasionally occurs, in this disease, from pyemia or purulent infection, as in the interesting cases related by Abercrombie, Watson, Wilde, Bruce, and others.

The symptoms of inflammation of the mastoid cells are not always characteristic, as the disease is liable to be confounded with inflammation of the middle ear and of the auditory canal. In general, it will be found that the patient has been laboring for some time past under otalgia, or aural discharge, probably consequent upon some eruptive fever, and that he bears the marks of dilapidated health, or of strumous disease. The pain, which is often excessive, is referred to the mastoid process or occipital region, both of which are extremely tender on pressure; the individual is feverish, thirsty, and restless; there are buzzing noises in the ear; the head is dizzy and aches violently; and delirium usually sets in at an early stage, always followed, when matter forms, by rigors and coma, if not also by convulsions, especially if there is grave cerebral involvement. Signs of suppuration frequently appear in the auditory canal, even when the pus of the mastoid cells makes no effort to escape by that route or by the drum of the ear, both of which, however, invariably show signs of inflammation at an early period of the attack, the former being red and swollen, the latter injected and opaque.

The treatment of inflammation of these cavities must be strictly antiphlogistic. Leeches and counter-irritation by blisters, with anodyne fomentations, light diet, irritating purgatives, and the antimonial and saline mixture, together with morphia to assuage suffering and promote sleep, are the most reliable remedies. Great relief always follows early and free incisions over the tender and inflamed surface, the knife being made to grate upon the bone. In chronic cases marked by a strumous taint, an issue in the nape of the neck, and the judicious use of quinine and iodide of iron, will be likely to prove beneficial. A gentle course of mercury, especially in the form of the bichloride, should be tried when the disease is unusually obstinate. When the brain is endangered by an extension of the morbid action, the tympanic membrane should be freely punctured, and the mastoid process promptly opened, to afford vent to the pent-up fluid, which is generally the direct cause of the cerebral mischief and of the carious or necrosed condition of the bone.

Fig. 259.



Necrosis of the Mastoid Process and Petrous Portion of the Temporal Bone.

Perforation of the mastoid process, originally suggested by Riolanus, in the seventeenth century, and first practised by Petit, in the eighteenth, may readily be performed with a common bone-perforator, a chisel and hammer, or a very small trephine, similar to that used in opening the maxillary sinus. A small aperture is generally quite sufficient to afford the necessary drainage and the introduction of the syringe for washing out the mastoid cells and middle ear, the fluid used for this purpose being tepid water with the addition of a few drops of chlorinated soda, or a minute quantity of permanganate of potassa. The opening, when the operator has his choice, is usually made in a diseased portion of bone, or at the site of a fistulous orifice, the mere enlargement of which is sometimes quite sufficient.

SECT. VIII.—OTALGIA.

Pain in the ear, otalgia, or earache, is of very frequent occurrence, especially in children and young persons, and may arise from a great variety of causes, as exposure to cold, inflammation of the membrane of the tympanum or of the auditory tube, gout and rheumatism, disorder of the digestive organs, and affections of the teeth. Sometimes it is of a purely nervous or neuralgic character, coming and going in regular paroxysms, like neuralgic pain in other parts of the body. Children, especially such as are of a delicate constitution, are very obnoxious to severe attacks of earache from exposure to cold. The suffering usually comes on in the evening, and is generally aggravated by recumbency, so that the patient is obliged to get up and walk the room, or, if he is a child, has to be supported in his nurse's arms. Earache, often of a very distressing character, is a common attendant upon measles and scarlatina; and, under such circumstances, as well as in many others, the probability is that it is merely a symptom of ordinary inflammation of some of the structures of the ear. What corroborates this view is the fact that the tympanum and auditory tube usually afford evidence of the morbid action, the former being red and injected, while the latter is exquisitely tender, and the seat of an inordinate secretion of cerumen.

Neuralgia of the ear is most common in children, although it may occur at any period of life, and under circumstances apparently the most opposite. Its causes are various, being sometimes purely local, at other times constitutional, while in a third series of cases they are of a mixed character. During my residence in Kentucky, where neuralgia in all its forms is exceedingly common, I met with several cases of this affection, which were unquestionably of a miasmatic origin. The paroxysms observed the same regularity as those of intermittent fever, recurring once in the twenty-four hours, or once every other day, lasting for some time, and then gradually disappearing; being generally preceded by chilly sensations, or even by a severe rigor, followed by a copious sweat, and promptly relieved by the ordinary antiperiodic remedies.

In the treatment of otalgia it is a matter of primary importance to obtain, if possible, a clear idea of the nature of the exciting cause, as upon a knowledge of this must depend the choice of our remedies. If the teeth are at fault, they must be extracted, or, at all events, put in order, before the subsidence of the local distress can reasonably be hoped for. When the attack has been caused by exposure to cold, the most efficient remedies are a hot foot-bath and a full dose of Dover's powder, along with hot drinks and warm applications to the ear. From three to twelve drops of laudanum, according to the age of the patient, should be introduced, tepid, into the affected organ, where it should be retained by means of raw cotton and a proper position of the head. When the distress is very violent, and the ordinary means fail, leeches should be applied behind the ear, and the bowels opened by a brisk cathartic, followed by an efficient anodyne diaphoretic.

In the neuralgic form of the disease, the best remedy is quinine, either alone or in union with strychnia, arsenious acid, and morphia. Colchicum will be of service when the affection is dependent upon gout or rheumatism.

SECT. IX.—NOISES IN THE EARS.

Among the more distressing affections of the ear are the various kinds of noises which so frequently accompany nervous deafness and other morbid states of this organ and its associated structures. These noises are so common in all classes and

conditions of persons as to have always attracted special attention. The older writers described them under the expressive name of "tinnitus," literally signifying a ringing or tinkling sound.

In regard to the character of the sounds, nothing could be more strange and diversified. Thus, in one case, they resemble the ticking of a watch; in another, the ringing of a bell; in a third, the buzzing of an insect; in a fourth, the chirping of a bird. Sometimes they are like the rustling of the wind among leaves, the pattering of rain, the roaring of a water fall, the motion of a saw-mill, the boiling of a tea-kettle, or the whistling of a steam-engine. Cases are met with in which they are of an explosive character, similar to the report of a pistol. Occasionally, again, they resemble the noise produced in filing. A throbbing, beating, or pulsatile sound synchronous with the contraction of the left ventricle of the heart, is sometimes noticed. In a case recorded by Roger, the noise was distinguished by auscultation, and readily arrested by pressure applied to the mastoid branch of the posterior auricular artery. Both ears may be affected simultaneously or successively, or one may suffer, and the other be free. In general, the abnormal sounds, whatever their nature may be, are confined to the ears, but sometimes they extend over the whole head, causing the most disagreeable and distressing feeling. Fatigue, loss of sleep, exposure to cold, damp states of the atmosphere, and the depressing passions, have the effect of increasing them, and of aggravating the patient's suffering, often inducing fits of the most dreadful despondency. Position also influences their intensity. Thus, they are often worse during recumbency than in sitting or standing, and conversely. Some persons suffer most at night after they retire, when the head lies on the pillow, and others when they are in an overheated room. Finally, they may be temporary or permanent, very slight or exceedingly annoying, according to the character of the exciting cause. The noises attendant upon confirmed nervous deafness generally continue, with, perhaps, an occasional transient improvement, during the remainder of life.

The causes of these various sounds are not always appreciable. Indeed, in many cases, the closest scrutiny fails to detect their real nature, or the influences under which they are developed. From the fact that they so commonly attend nervous deafness, it has generally been supposed that they are mainly, if not entirely, due to disease of the auditory nerve; but that they may also exist independently of such lesion is equally true. Most distressing buzzing, tinkling, or ringing usually accompanies obstruction of the meatus from the retention of indurated wax; inflammation of the ear is invariably characterized by various abnormal sounds; and similar effects are always produced by mechanical occlusion of the Eustachian tube, whether the result of thickening of its lining membrane, or of the presence of mucus, lymph, or blood. In a remarkable case, referred to in a previous page, the most distressing noise in the ear was found, upon dissection, to have been occasioned by the lodgment of a small grain of barley in the faucial extremity of this tube. Very annoying tinnitus always accompanies inflammation, thickening, ulceration, and rupture of the tympanic membrane. Various disorders of the system, as anemia, dyspepsia, constipation of the bowels, and diseases of the brain, may give rise to abnormal sounds in the ears. The ringing noises of the ears in typhoid fever have long been familiar to the physician.

The *treatment* of tinnitus is altogether empirical. The great point to be borne in mind is that the noise is merely a symptom, not a disease. Hence, the first step, in every case, is to ascertain, if possible, the nature of the exciting cause, and the second to remove it. Inflammation is combated, the inspissated wax or foreign body extracted, the catarrh relieved, the Eustachian tube cleaned out, and the general health, if at fault, amended. To lay down any other rules would be absurd. The distressing noises which so commonly accompany nervous deafness are usually utterly irremediable.

For the cure of these noises in the ear, and the concomitant deafness, Dr. F. E. Weber, of Berlin, has proposed tenotomy of the tensor muscle of the tympanum, the object being the removal of the abnormal intratympanic and intralabyrinthal pressure, the supposed cause of their production. The patient being seated in a chair with the head tightly strapped, and the ear illuminated with a mirror, the knife, hook-shaped, and moved by a lever contrivance attached to the handle, is passed through the membrane of the tympanum, in front of the manubrium, when it is slightly depressed in order to reach the tendon of the muscle, which is then care-

fully divided by a push of the slide of the instrument. The pain is somewhat sharp, but soon subsides. To prevent the ends of the tendon from uniting by cicatricial matter, the tympanic membrane is drawn outwards, from time to time, by the exhaustion of the air in the external meatus and by the inflation of the Eustachian tube, the treatment being commenced as soon as the opening in the drum is closed, as will usually be the case in six or eight days. Dr. J. A. White, of Baltimore, who has published a very good account of this operation, states that he has in numerous instances witnessed its beneficial effects in the rapid subsidence of noise and the improvement of hearing.

CHAPTER VII.

DISEASES AND INJURIES OF THE FRONTAL SINUS.

THE affections of this cavity may be said to resemble, in their general characteristics, those of the maxillary sinus and of the nose. The most important are inflammation, abscess, fractures, foreign bodies, polyps, hydatids, and malignant disease; but, owing to their great infrequency, their diagnosis is generally very difficult, and their treatment unsatisfactory.

1. *Inflammation* of the frontal sinus may be provoked by external injury, as a fall, or blow on the forehead; but, in general, it is caused by the effects of tertiary syphilis, or by an extension of disease from the nose, by continuity of structure through the Schneiderian membrane. However induced, it is characterized by a sense of weight and fullness, and by a dull, heavy, aching pain along the eyebrow, accompanied, in most cases, by sneezing and a discharge of watery mucus from the nose, with lachrymation and suffusion of the eye, more or less cephalalgia, and other evidences of indisposition, such as attend the more severe forms of coryza. An unusual amount of mucus is no doubt poured out into the sinus, and, when the inflammation is at all severe, this, acting obstructingly, or not finding a ready outlet, may seriously aggravate the patient's suffering.

The treatment must be by leeching over the affected sinus, active purgation, and diaphoretics; aided, as the morbid action declines, by sternutatories, with a view to their revulsive effect upon the mucous membrane of the nose.

2. When the inflammation passes into *abscess*, the occurrence will be denoted by an increase of the local suffering, the pain assuming a throbbing, tensive, pulsatile character, and by excessive headache, delirium, and rigors, followed by high febrile disturbance. The forehead and eyebrow are swollen and tender, and, if the matter does not soon find an outlet, an erysipelatous blush will appear upon the surface, an almost unerring sign of the nature of the disease. If the case is misunderstood, or improperly treated, the morbid action may extend to the brain, or cause caries or necrosis of the walls of the sinus, as occasionally happens when the abscess is the result of tertiary syphilis.

The pus may find an outlet through the nose, or through the anterior wall of the sinus, although such an event must necessarily be extremely uncommon. Occasionally, as when the quantity is unusually great, it passes into the other sinus, by breaking down the intervening septum. When it flows off by the nose, the patient is apprised of the fact by the use of his handkerchief.

The treatment must be conducted according to the ordinary principles of practice. If the case is urgent, as indicated by the cerebral disturbance and the erysipelatous condition of the forehead and eyebrow, the soft structures should be freely divided and a small opening made, by means of a suitable trephine, into the most dependent part of the sinus, which may afterwards, if necessary, be injected with anodyne and detergent lotions to promote the cure.

3. *Fractures* of the walls of this cavity are uncommon. They may be caused by falls, blows, kicks, or gunshot injury, and may, therefore, be either simple, compound, or comminuted. A curious phenomenon, occasionally witnessed in these accidents, is an emphysematous condition of the scalp, face, and eyelids, produced

by an escape of air from the nose into the surrounding connective tissue. The injury, whatever may be its character, must be treated upon the same general principles as fractures in other parts of the skull. When the outer table is depressed, so as to occasion serious disfigurement, elevation must be attempted, either with the lever alone, or with this instrument and the trephine. Loose splinters and any foreign matter that may be present should, of course, be promptly and thoroughly removed.

4. The frontal sinus is occasionally the receptacle of *foreign bodies*, either formed within, or introduced from without; more generally the latter. Thus, Bartholin speaks of having met with earthy concretions, similar to those which are sometimes found in the nose. Several authors assert that they have seen worms in it, the number, in one case, exceeding seventy; their development having, doubtless, been due to larvæ deposited in the nose, whence the maggots crept into the frontal sinus. The annals of surgery supply us with a number of examples of the lodgment of balls in this cavity in cases of gunshot wounds; and there are also several instances on record where the end of a knife-blade or scissors, broken off in its passage through the skull, was arrested in it. A case has been recorded by Mr. Fell, in which the iron bolt of a gun-barrel, burst in the act of being discharged, was so deeply imbedded in the frontal sinus that its presence remained undetected for many days: it was finally extracted, and a good recovery followed.

The presence of a foreign body in this situation must necessarily be productive of pain, a sense of weight and fullness, and, probably, also, more or less tumefaction in the forehead and eyebrow. No diagnostic value can, however, be attached to these symptoms. When the foreign body has been introduced from without, the nature of the case may easily be determined simply by its history. The proper remedy in these cases is, of course, extraction, a suitable opening being made into the anterior wall of the sinus by means of a trephine.

The after-effects of a wound of the frontal sinus are sometimes troublesome. In a case reported by Dupuytren, the integument, after the cicatrization of the parts, was always elevated, when the patient blew his nose, into a little swelling near the temple, which gradually subsided again. It was, doubtless, owing to the passage of the air through an opening in the wall of the sinus, and was cured in a fortnight by compression with a small pad.

5. *Polyps*, of a gelatinoid or fibroid structure, are sometimes developed in the frontal sinus, or extend into it from the nose, forcing apart its walls, and causing more or less pain and deformity, but affording no pathognomonic signs. In time, the overlying bone becomes softened and attenuated by the pressure of the tumor, crackling under the finger like parchment. Viallet and Rouger met with a case in which a polyp of the frontal sinus was associated with an exostosis of this cavity; and several instances have been recorded in which a tumor of this kind coexisted with a similar formation in the nose and maxillary sinus. Removal is effected with the knife and gouge, or knife and trephine, a crucial incision being made through the integument of the forehead so as to admit the surgeon's finger and instruments.

6. Langenbeck and Brunn have each recorded the particulars of a case of what they call *hydatids* of this sinus, but which, I suppose, were really only serous cysts. The tumor, during the progress of its development, encroaches upon the forehead and roof of the orbit, pushing the eye forward and downward, and thus occasioning serious deformity. The diagnosis must necessarily be obscure. As the disease advances, however, the anterior wall of the sinus will be rendered so thin as to yield under the pressure of the finger, and admit of the detection of fluctuation. In doubtful cases, important information might be elicited by the exploring needle. The proper remedy is excision.

Robert Keate, in 1819, published, in the tenth volume of the London Medico-Chirurgical Transactions, the particulars of a case of so-called hydatids of the frontal bone, in a girl eighteen years old, but the tumor seems to have been developed in the areolar texture, and not in the sinus, which, however, became accidentally involved during the progress of the disease.

7. *Malignant disease*, particularly of an encephaloid or sarcomatous character, of the frontal sinus is probably more common than is generally imagined. Of the former affection I have myself seen only one case. The patient, a gentleman, upwards of sixty years of age, had been seized, twelve months previously, without any assignable cause, with what he supposed to be an attack of erysipelas of the forehead

and face. On recovering, he noticed an unusual fullness over the left eyebrow, attended with great hardness and excessive pain. The lids continued to swell, and the left nostril, by degrees, became obstructed, and the seat of a thin, sanious discharge, more or less profuse, and, at times, quite fetid. At length several openings formed upon the most prominent part of the tumor, giving vent to thick, yellowish pus, and readily admitting of the passage of a probe into the nose. Upon enlarging these openings, the sinus was found to be occupied by a soft, fungous mass, the overlying bone being softened and disintegrated. The morbid growth presented all the characteristics, physically and microscopically, of encephaloid. The patient passed out of my hands in a few weeks, and died soon after completely exhausted.

Of scirrhus, colloid, and melanosis of the frontal sinus, the annals of surgery do not, so far as I know, afford a solitary example. Epithelioma occasionally occurs here, generally as a consequence of an extension of the disease from the neighboring structures. Of its clinical history, as a primary affection, nothing is known.

CHAPTER VIII.

INJURIES AND DISEASES OF THE NOSE AND ITS CAVITIES.

SECT. I.—AFFECTIONS OF THE NOSE.

THE nose is subject to various affections. The most common are wounds, furuncular inflammation, syphilitic and malignant ulcers, hypertrophy, and deformities.

1. *Wounds*.—Wounds of the nose, whether incised or lacerated, demand the nicest adaptation of their edges, and the most careful maintenance by wire sutures, introduced with a properly curved needle. Adhesive strips may be necessary to aid the approximation. Any tendency of the parts to fall in towards the nose should be counteracted by filling the nostril with a roll of lint; few cases, however, will require such interference.

2. *Furuncular Inflammation*.—The nose, especially its tip, is liable to a form of boil, which, from the severity of the attendant pain and disfigurement, deserves special attention. I have seen it most frequently in young and middle-aged subjects, of intemperate habits, but it is also met with in the old, particularly in huge feeders and in persons who neglect their bowels and take but little exercise in the open air. It begins either in the subcutaneous areolar tissue or beneath the perichondrium, from which it gradually extends to the skin and fibro-cartilage, and is characterized by violent, throbbing pain, a sense of excessive tension, great swelling, and a dusky, brownish, or livid appearance of the surface. In the more severe grades of the disease, the pain extends over the entire face, as high up as the forehead and temples, and there is more or less febrile disturbance with loss of appetite and sleep. Suppuration gradually sets in, and the matter finally discharges itself either through the skin or through the nose, not, however, without great aggravation of suffering owing to the peculiar firmness of the overlying structures. The disease, which generally depends upon some constitutional cause, rarely, if ever, aborts, even with the aid of leeches, iodine, and active purgation. To allay suffering and prevent the occurrence of an unseemly scar, the best plan is to make an early puncture with a narrow-bladed tenotome, passed from the septum upwards in close contact with the ala of the nose.

3. *Syphilitic Ulcers*.—Syphilitic ulcers of the nose, commencing in the skin or mucous membrane, and gradually extending to the fibro-cartilaginous case, are sufficiently common, as a tertiary effect. They are generally associated with signs of syphilis in other parts of the body, and are liable, if neglected or improperly treated, to terminate in horrible deformity of the features. The most reliable diagnostic phenomena are, the history of the case, the multiple character of the sores, the rapid progress of the disease, and the inflamed and indurated condition of the surrounding surface. The accompanying pain, usually very slight, is liable to nocturnal exacerbations. The most appropriate measures are the iodides, with bichloride of mercury, and dilute acid nitrate of mercury, until the ulcers begin to granulate, when the best dressing will be some mildly stimulating ointment.

4. *Discoloration*.—A singular discoloration of the nose, known as rose acne, and vulgarly called the red nose, is sometimes observed, more especially in elderly subjects addicted to the pleasures of the bottle and of the table, although the young and temperate are by no means exempt from it. It is frequently, if indeed not generally, associated with enlargement of the hair follicles and with hypertrophy of the skin, and appears to be essentially due to a habitually dilated and engorged condition of the capillary vessels, giving the part a somewhat tumid and livid, lilac or purplish hue. Under pressure the blood slowly disappears, while under mental excitement the quantity naturally increases, and thus heightens the discoloration. The affection, which is usually confined to the tip and alæ of the nose, is generally very obstinate, and, from its conspicuous character, a source of much annoyance. In the milder cases benefit may be derived from the use of Goulard's extract, a weak solution of bichloride of mercury, dilute tincture of iodine, zinc ointment, and the occasional application of a few leeches. Depletion by puncture is sometimes serviceable. In the more intractable forms of the disease, I have found nothing so useful as extensive subcutaneous division of the affected vessels with a delicate tenotome. The drainage is copious; the shrinkage rapid and decided.

5. *Varicose Veins*.—A varicose state of the veins of the nose is occasionally met with, chiefly in elderly subjects, in conjunction with a similar condition of the veins of the face. Their most common situation is the side of the nose. When very large and numerous, they impart a peculiar bluish, lilac, or livid appearance to the skin, which is, perhaps, at the same time, coarse, thick, and rugose, particularly in cases of long standing, and in persons of intemperate habits. Occasional depletion of the engorged and dilated vessels by puncturing them with a bistoury will afford temporary relief. A permanent cure is best effected by injections of subsulphate of iron, so as to produce a firm coagulum, upon the absorption of which the vessels gradually shrink to their normal size. It is not often, however, that any surgical interference will be necessary.

6. *Nævus*.—Nævus of the nose is generally, as in other regions, a congenital affection, of variable extent and shape, soft, compressible, expansible, and of a reddish, scarlet or purplish color, according to the predominance of the arterial or venous structure. Permitted to progress, it may, eventually, acquire a considerable size, and thus occasion serious disfigurement. The proper remedy is removal, either with the knife, or, what is commonly preferable, by strangulation with pins and ligatures. If Vienna paste be used, great care should be taken, lest its influence extend to the bones and cartilages.

When the nævus involves the nasal septum or the wings of the nose, the most suitable remedies are repeated injections of subsulphate of iron, the introduction of numerous ligatures, and the subcutaneous division of the abnormal structures with a delicate bistoury. Ligation and excision will inevitably be followed by disfigurement.

7. *Sebaceous Tumor*.—The sebaceous tumor of the nose is uncommon; it is of slow growth, and seldom attains any considerable bulk. The side and tip of the organ are equally liable to it. Its tardy development, small bulk, freedom from pain, and soft, compressible consistence are its chief diagnostic features. The proper remedy is extirpation.

8. *Lipomatous Tumor*.—There is a curious affection of the nose—so curious generally as to excite the risibility of the observer—to which the term lipoma is applied, from the fact that it essentially consists in accumulation of the subcutaneous adipose

Fig. 260.



Lipoma of the Nose.

substance, along with marked hypertrophy of the integument. The drawing, fig. 260, borrowed from Liston, exhibits the disease in an extraordinary degree of development. The tumor has a lobulated appearance, or, more correctly speaking, it is composed of several distinct masses, having, seemingly, one common origin. The growth, which is always chronic and painless, is almost exclusively confined to elderly male subjects with a ruddy complexion and an active capillary circulation, addicted to the pleasures of the table and to alcoholic potations. The chief inconvenience which it produces is of a mechanical character, obstructing vision, compressing the nostrils, and interfering with eating and drinking. Occasionally the surface becomes very red and inflamed, and may, in time, even ulcerate. The sebaceous glands are sometimes much involved in the morbid action, being enlarged, obstructed, and transformed into distinct cysts.

The only remedy for this disease, when it has attained any considerable development, is excision: when small and of recent standing, removal may sometimes be effected by sorbefacient applications, especially the tincture of iodine, a change of the patient's habits, and the steady use of purgatives. When excision is determined upon, the surgeon may expect to encounter a good deal of hemorrhage, owing to the enlargement of the cutaneous and other vessels, but this may usually be effectually controlled by ligature and compression. Care should be taken not to inflict any injury upon the cartilages of the nose, as the morbid mass is generally very firmly adherent to them. Sir William Blizard met with an instance in which the patient died of hemorrhage after an operation for lipoma.

9. *Fibroid Tumor*.—The fibroid tumor, also of very rare occurrence, generally springs from the surface of the fibro-cartilage of the nose, lying immediately beneath the perichondrium, and exhibits the same structure as similar growths in other parts of the body. It is of a hard, compact, consistence, unaccompanied by pain, change of color in the skin, or enlargement of the subcutaneous veins, seldom attains much bulk, and occasionally recurs after extirpation.

10. *Hypertrophy of the Skin*.—The skin of the tip of the nose is liable to hypertrophy, sometimes congenital, but more commonly acquired. The enlargement exists in various degrees, and may be so great as to occasion very unpleasant disfigurement. It is often associated with varicosity of the subcutaneous veins, and consists essentially in a thickened condition of the skin, without any material alteration of the other tissues. The only remedy is retrenchment of the affected structures.

11. *Nævoid Elephantiasis*.—There is a variety of hypertrophy of the skin and cellular tissue of the nose, in which these

tissues are not only greatly enlarged, but occupied by a cavernous structure, interspersed with tortuous veins and arteries. In a case of this description, occurring in a female 36 years of age, a patient, at the College Clinic, in 1870, from whose nose I had removed a congenital nævus thirteen years previously, the organ was converted into a tumor, fig. 261, which measured seven inches in circumference, and four inches and a half in its vertical, by nearly six inches in its transverse, diameter. The skin, greatly thickened, nodulated, and inlaid with enlarged vessels, was dense and firm, and grated under the knife. The cellular tissue was of a hard, fibrous consistence, and highly vascular, while the cartilages, particularly the lower lateral, were involved in the general hypertrophy. Retrenchment was attended with troublesome hemorrhage, but the appearance of the nose was very greatly improved by the operation.

12. *Epithelioma*.—Carcinoma of the nose, chiefly of the epithelial character, occurs principally in elderly subjects, and, according to my experience, more frequently in women than in men. Arising either as a fissure, a tubercle, or a warty

Fig. 261.



Nævoid Elephantiasis of the Nose.

occurs principally in elderly subjects, and, according to my experience, more frequently in women than in men. Arising either as a fissure, a tubercle, or a warty

excrecence, it gradually proceeds from bad to worse, until, at length, an ulcer forms, the tendency of which is to spread in every direction, and to discharge a thin, ichorous, irritating fluid. The sore is indisposed to heal, and is the seat of more or less pain, smarting, burning, or itching. The disease often lasts for years, now stationary or slightly advancing, but sure in the end to commit serious ravages.

Epithelioma of the nose should not be confounded with syphilis. The history of the case will generally, of itself, be sufficient to establish the diagnosis, superadded to the fact that the carcinomatous ulcer is nearly always single, while the syphilitic is commonly multiple. There is also, in the former affection, less discoloration in the adjacent surface.

The treatment is the same as in epithelioma generally. The most trustworthy remedies are arsenic and iron, aided by the dilute ointment of acid nitrate of mercury with an occasional leech to the neighborhood of the ulcer. Lotions of zinc and nitric acid also prove serviceable.

13. *Rhinoplasty*.—The nose, from accident or disease, may be so impaired in its form and size as to require reconstruction by the aid of plastic surgery. The operation which is performed for this purpose is, accordingly, denominated rhinoplasty. The lesion for which, in civilized countries, interference is usually demanded, is constitutional syphilis, or the joint action of syphilis and mercury, which often destroys nearly every portion of the nose, except, perhaps, a small vestige of the bridge, causing, thereby, the most hideous deformity. The horror and distress of the case are greatly increased when the ravages extend to the frontal sinuses, the lachrymal passages, the upper lip, the ethmoid and spongy bones, and the soft and hard palate; in the latter event, throwing the nose and mouth into one immense cavern, an occurrence which not only seriously affects the speech, but readily admits the passage of food and drink from the latter into the former.

The deformities of the nose requiring plastic interference may very properly be arranged under the following heads:—1. Loss of the entire organ, bones as well as soft parts. 2. Destruction of the whole or greater portion of the cartilages, the bridge remaining intact. 3. Mutilation of the tip, as when a small piece is cut or bitten off, including a part of both wings. 4. Loss of one wing, either alone or together with the nasal column. 5. Perforation of the nose, either on the top or at the side; in the latter case, with or without participation of the cheek. 6. Sinking of the organ from destruction of the cartilaginous septum of the nose, the soft structures being but little, if at all, affected. 7. Loss of the column. 8. Mutilation of the nose and upper lip, or the nose, lip, and cheek.

For the repair of these various defects, some of the nicest processes of the art and science of surgery are required; but, even with the very best skill that can be employed in their application, success is by no means always to be looked for; on the contrary, the surgeon will too often have occasion to lament the occurrence of some unexpected or unavoidable event which frustrates his hopes, and disappoints the expectations of the patient. It is, therefore, of the greatest consequence, as stated in the general chapter on plastic surgery, that everything should be done beforehand calculated to insure a favorable result. If the operation is entered upon heedlessly, or without due preparation of the part and system, failure will almost be certain.

The substance required for closing the chasm in the nose may be borrowed from the immediate vicinity of the organ, or from some distant part. In the Indian method, as the first proceeding is usually called, the flap is obtained either from the forehead, the cheek, the upper lip, or the nose itself, according to the exigencies of each particular case. In the other procedure, which bears the name of Tagliacozzi, in commemoration of its inventor, or "the Italian method," from the country of his nativity, the operculum is taken from the arm. The operation, however, chiefly in consequence of the tedious and painful confinement of the head and limb, is now seldom employed, although instances occasionally arise in which it may be done with great advantage.

When an entire nose is to be reconstructed, the Indian method certainly deserves the preference, provided it is possible to obtain the requisite amount of substance from the forehead. Supposing that everything is favorable to the operation, the first step will be to measure off the shape and size of the flap. For this purpose, the defective part should be replaced with a wax mould, a piece of gutta-percha, or a lump of dough, representing as accurately as possible the outline and dimensions of the original organ. A piece of soft leather is then stretched over the artificial nose,

to the shape of which it is cut with great care, including the column, or central portion. Another piece of leather, one-third larger than the former, is then fashioned, this addition being necessary to provide against shrinkage, which, in time, generally reaches fully this extent, if it does not exceed it. As a general rule, it may be stated, that the flap should be from two inches and three-quarters to three inches in length, by two inches and a half in width at its widest part. In this length is included the column, which should be about one inch and a quarter in length, and from six to eight lines in width, according to the breadth of the nostrils. When the column is borrowed from the lip, the caudiform portion of the flap is of course omitted. The pedicle of the new nose must be from six to nine lines in width, and so long as not to displace the left eyebrow when it comes to be twisted upon itself, which, for the sake of convenience rather than anything else, is usually from left to right. The shape and size of the flap are to be carefully mapped off, immediately before the operation, with tincture of iodine, the preference being always given to the central portion of the forehead, unless there are contra-indications, in which event it should be taken from one side. The shape of the flap, and the manner of forming it are shown in fig. 264.

These preliminaries having been gone through, the patient, placed recumbent, with the head and shoulders gently elevated, is put under the influence of chloroform, it being desirable that he should be as passive as possible during the operation. A roll of lint being now inserted into each nostril, to prevent the ingress of blood, an incision is made with a very sharp, narrow scalpel, along the iodinated track. The cut on the right side is extended down, close along the brow, to the root of the nose, while on the left side it reaches hardly as low as the level of the brow, being prolonged afterwards, if it should be deemed advisable. In performing this part of the operation, it is of the utmost importance not to interfere with the angular artery, as the vascular supply of the new nose will mainly depend upon its integrity. The structures are divided, at the first stroke of the instrument, down to the periosteum, which is left intact. The gap in the forehead being now sponged, and the bleeding arrested by ligature, its edges are immediately brought together by several points of the interrupted suture and adhesive strips, as little being permitted to remain open as possible.

The next step of the operation consists in paring the edges of the mutilated organ, and removing such redundancies as may be in the way of the new material. The skin over the bridge of the nose should also be slightly revived in order to facilitate adhesion between the contiguous surfaces.

In the third step of the operation the parts are stitched together by the common interrupted suture; or, what is preferable, by the tongue and groove suture of Professor Pancoast. In order, however, to do this properly, it is necessary that the edges of the flap should have been previously beveled off on the cuticular surface for about the eighth of an inch, as may readily be done in the act of forming it by running the knife along obliquely. The edges of the nose are beveled from without inwards, so as to form a groove for the reception of the tongue, an arrangement which thus brings together four raw surfaces. The connection is affected by passing a loop of thread with two needles, first through the inner lip of the groove, then through the base of the tongue, and lastly through the outer lip of the groove, all

Fig. 262.

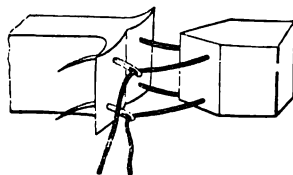
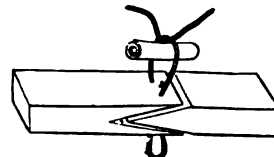


Fig. 263.



Dr. Pancoast's Tongue and Groove Suture.

on the same level. The ends of the thread are then tied over a thin roll of adhesive plaster, thereby forcing the tongue deep into the groove. The number of sutures on each side must vary from three to five, according to the extent of the wound. The annexed cuts will serve to convey a better idea of making this ingenious suture than

any description, however elaborate. Fig. 262 exhibits the mode of introducing the thread, and fig. 263 the manner in which the tongue is received into the groove.

All that now remains to be done is to fix the caudal portion of the flap, intended for the column, in its proper position, a procedure requiring great care and attention in order to secure its adhesion. For this purpose a deep transverse opening is made in the upper lip, at its junction with the natural septum of the nose, from three to five lines in length, into which the extremity of the strip, previously divested of cuticle, is firmly implanted, a few points of suture being employed to keep it in place.

The lint inserted into each nostril, prior to the operation, is now replaced by a fresh tent of the same material, inclosing a small gutta-percha tube, to prevent the adhesion of the opposite surfaces, as well as to facilitate respiration. Narrow strips of isinglass plaster being stretched across the sides of the nose, to effect more uniform approximation, the dressing is completed by applying a layer of charpie, wet with oil, along the line of suture, to prevent the edges from becoming dry and shrivelled. The greatest care is used that, while the contact is complete, there shall be no undue tension anywhere. The diet is light and cooling, the temperature of the room is regulated by the thermometer, and the head is well elevated by pillows. An anodyne is given immediately after the operation, and the dressing is not disturbed until the end of the third day. New tents are now introduced into the nose, and any sutures that are loose removed; otherwise they are not disturbed.

When, as occasionally happens, the pedicle of the flap is redundant, giving the upper part of the nose, especially on the left side, a full, unseemly appearance, the defect may be remedied by the removal of an elliptical portion of integument, care being taken not to perform the operation until the organ is fully capable of sustaining an independent existence.

The adjoining sketches afford a good idea of the success which often attends rhinoplasty, when properly executed. Fig. 264 exhibits the appearance of the parts prior to the operation, and fig. 265 nearly twelve months afterwards. The operation

Fig. 264.



Fig. 265.



Rhinoplasty and its Results.

was performed at the College Clinic, in 1856, with the aid of the tongue and groove suture, and the result was, in every respect, most gratifying, the organ remaining up to the present moment large and well shaped. It is proper to add that the flap was uncommonly large, as it always should be, and that it united throughout by the first intention.

In some of the more recent rhinoplastic operations, the periosteum of the forehead was included in the flap; and the results in a few of the cases, thus treated, are reported to have been most satisfactory, new bone having been formed in from six to eight weeks after the transplantation was effected. Whether the procedure,

for the first practical application of which we are indebted to Professor Langenbeck, of Berlin, really possesses any advantage over the ordinary method, can only be determined by further experience. Observation has fully established the fact that the frontal bone suffers no material injury from the removal of its fibrous investment, as it is very freely supplied with blood from within.

A very good nose may often be constructed by taking the necessary substance from the cheeks, especially if they are tolerably full and lax. A flap of integument, with the base looking upwards, is raised on each side of the nose, and stitched to its fellow along the middle line. The two gaps heal by the granulating process, but their size may generally be materially diminished by drawing the edges together with wire sutures.

The Italian operation has undergone several modifications. As originally executed by Tagliacozzi, and afterwards by his immediate disciples, it was a most tedious and trying procedure, well calculated to put severely to the test the patience both of the subject and the surgeon. The first step consisted in forming a suitable flap of integument at the inner and middle part of the left arm, over the flexor muscle, at least four inches in length by three and a half in width, its outline having previously been traced with ink. Two longitudinal incisions being made, the integument was carefully raised in its entire extent, or as far as the two transverse lines, and a piece of soft linen, well oiled, passed beneath it, to prevent reunion. The wound, which in the modern process is closed by suture under the bridge, was left to suppurate, and, at the end of a fortnight, the flap, now thickened, hardened, and

shrunk, by exposure, and covered with granulations on its posterior surface, was liberated at its superior extremity, which was then accurately stitched to the mutilated organ, the edges of which had been previously revived for its reception. To prevent the sutures from giving way, the limb was brought up close to the head, and maintained in that position by an ingenious, but complex, apparatus, consisting of a cap and jacket, made of strong drilling; the arrangement and mode of application of which may be easily understood from the sketch, fig. 266, copied from the original treatise of Tagliacozzi.

Another fortnight having been permitted to elapse, to afford the parts time for uniting, the flap was detached from its connection with the arm, and, after being properly fashioned, accurately fixed in the position which it was destined to occupy.

Tagliacozzi has left no statistics of his rhinoplastic operations, and we are, therefore, left in ignorance as it regards his success. From the great care, however, with which he has described his process, and from the fact that he attended numerous patients from abroad, it is reasonable to conclude that his success was highly flattering.

He was evidently a most ingenious and skilful surgeon, far in advance of his age; and in the operation of reconstructing noses he dwells with great force and point upon the importance of having the adscititious parts of unusual dimensions, thus providing against the effects of shrinkage, one of the great obstacles to the formation of a good organ.

Professor Graefe, of Berlin, modified the operation of Tagliacozzi, by attaching the flap at once to the mutilated nose, thus limiting the period of the constrained position of the head and limb to five or six days, this being generally found sufficient to insure adhesion between the parts. The actual value of this process, now usually known as the German method, has not been fully tested, but my opinion is that, while it answers very well in some cases, it is, on the whole, inferior to the original plan, since it lessens the chances of reunion, and admits of greater shrinkage after the operation. In the Italian procedure, the new material, from its exposed situation, acquires a more vigorous circulation, as well as a greater degree of solidity

Fig. 266.



Tagliacozzi's Apparatus.

and thickness, thereby fitting it the better for the maintenance of its new relations. Dr. J. Mason Warren, adopting the German modification of the Italian method, occasionally took his flap from the anterior surface of the forearm, about two inches above the wrist, and generally succeeded in effecting an admirable cure, the transplanted skin being separated on the fifth day.

Small apertures, of an oval or circular form, the result of wounds, ulceration, or gangrene, are met with on various parts of the nose, and may generally be readily closed by the transplantation of a suitable flap from the cheek, the forehead, or even the nose itself, according to the circumstances of the case. A similar procedure will be required when there is partial destruction of the edge of the nose. When one of the wings is lost, it will generally be necessary to borrow the flap from the arm or forehead. When the nasal column is deficient, an admirable substitute may easily be obtained from the central portion of the upper lip, either by twisting the flap at its pedicle, or by everting the mucous membrane, the surface of which soon assumes the character of the cuticular tissue.

The nose is sometimes unseemly depressed, or caved in, in consequence of the destruction of its cartilaginous septum, without, perhaps, any injury of the skin, giving it more or less of an African expression. For such a defect, the only remedy is the construction of a new organ, all attempts to elevate the parts in a satisfactory manner proving useless for the want of proper support.

These operations upon the nose do not always turn out so well as could be desired. Sometimes the result is spoiled by hemorrhage, coming on secondarily, perhaps several days after the parts have been adjusted, so as effectually to prevent the adhesive process. Occasionally the flap is assailed by erysipelas. Such an event is most likely to ensue in persons of unsound constitution, and in those whose systems have not been properly prepared for the undertaking. The most common cause, however, of all is the want of nourishment in the flap, in consequence of the small size or great paucity of its vessels, or of the partial arrest of the circulation from the pressure of the dressings. The best protection against such an occurrence is the retention of a pretty thick layer of cellulo-adipose tissue, in which the vessels can have full sway in the performance of their functions. The result is, generally, essentially influenced by the after-treatment. Even when the success is apparently most perfect, the effect may afterwards be marred by the recurrence of the original disease, by which the mutilation necessitating the undertaking was caused. Finally, the operation is not without danger, as is shown by the fact that it has sometimes proved fatal. Dieffenbach, during one of his visits to Paris, lost two patients out of six, probably, as has been conjectured, because sufficient attention had not been paid to the preparation of the system and to the subsequent treatment.

SECT. II.—AFFECTIONS OF THE NASAL CAVITIES.

The nasal cavities are liable to various accidents and diseases, of which the most important are hemorrhage, ulceration, polyps, hypertrophy of the mucous membrane, certain malformations, and foreign bodies.

1. *Rhinoscopy*.—For examining the anterior portion of the nasal cavity, the most convenient instrument is that of Duplay, delineated in fig. 267. It consists of two

Fig. 267.



Duplay's Nasal Speculum.

Fig. 268.



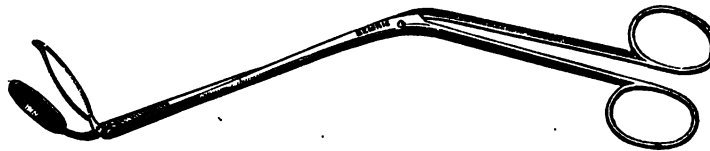
Metz's Nasal Speculum.

branches, of which that corresponding with the nasal septum is fixed and somewhat flattened, while the other, intended to dilate the nostril, is movable, and regulated

by a nut. The speculum of Metz, of Aix-la-Chapelle, consisting of two angular, polished, metallic portions, one of which is represented in fig. 268, is useful for lighting up those parts of the cavity which cannot be brought into view with the ordinary instrument. They may be employed together or separately, and they should be heated, previously to their introduction, by plunging them into hot water, to prevent the condensation of moisture on their surfaces. The patient should be seated upon a chair, with the head thrown well back, in order that the light may readily penetrate the nares. If the sun is not sufficiently bright, the inspection may be conducted with the aid of artificial light.

Inspection of the posterior nares, and the adjacent parts, may very satisfactorily be conducted with the instruments employed for laryngoscopic examinations, the uvula and soft palate having been drawn forwards with a flat hook or the noose of Türk. When it is, at the same time, necessary to have one hand free, for the purpose of operating, or applying local remedies, the instrument of Duplay, fig. 269,

Fig. 269.



Duplay's Rhinoscope.

which is a modification of that of Dr. Simrock, of New York, will be found useful, as it combines the mirror and hook, and can, therefore, be used with one hand.

Rhinoscopy was first practised by Bozzini, in 1807; but it was almost forgotten, until it was revived by Czermak, who has devised various useful instruments for its performance.

2. *Cleansing and Medication of the Nasal Passages.*—For cleansing, disinfecting, and deodorizing the nose, the most eligible procedure is that of Dr. J. L. W. Thudichum, of London, founded upon the discovery of Professor Weber, of Halle, that when one side of the cavity is filled through one nostril with fluid by hydrostatic pressure, while the patient breathes through the mouth, the soft palate so completely closes the nares as to force the fluid directly from one orifice into the other, without allowing any to descend into the pharynx.

Fig. 270.



Nasal Douche.

The apparatus for accomplishing this object consists of a glass vessel capable of holding from one to two pints, which is open above, and connected at its lower part with an India-rubber tube from thirty-six to forty inches in length, and surmounted by a stop-cock and a perforated nozzle. The patient, seated in front of a basin, with his head slightly bent over it, breathes entirely through the mouth, and refrains from swallowing. The nozzle being inserted into one of the

nostrils, and held there by the patient, while the vessel is elevated above the head, the stop-cock is opened, when, in a few seconds, a continuous and rapid stream will be seen to issue from the opposite cavity into the receiver below. Some little practice is necessary to insure the success of the operation, which is always more or less difficult in nervous females, children, and young persons.

When Thudichum's apparatus cannot be obtained, an ordinary syringe, capable of holding from four to six ounces, may be used. The nozzle should be well perforated, and inserted some distance into the nostril. Injections of the nasal cavity, through the posterior nares, are not only difficult, but unsatisfactory.

The most unexceptionable articles for washing out and medicating the nasal cavities are tepid water, impregnated with a little common salt, and the various solutions mentioned under the head of ulceration. Whatever substance be employed, care should be taken that it does not cause pain or irritation, otherwise it will be sure to create mischief. The injection should not, on an average, be repeated oftener than twice in the twenty-four hours; very frequently, indeed, one will suffice.

The inhalation of medicated sprays, either warm or cold, may be advantageously employed in the same class of affections as injections, with the same kind of medicinal agents. For this purpose, the steam atomizer will be more convenient than the handball apparatus.

Unguents of different kinds, very greatly diluted, may sometimes be beneficially employed for the nose, especially in ulceration of the cartilaginous septum, and of the anterior extremity of the turbinated bone. The application is best effected with a short, stiff, camel-hair pencil. The most efficacious salve, according to my experience, is the ointment of nitrate of mercury, diluted with six to eight or ten times its weight of simple cerate. A combination of glycerine and tannic acid is also very serviceable.

3. *Hemorrhage*.—The mucous membrane of the nose, from its great vascularity, is a frequent seat of hemorrhage. The exciting cause may be external violence, as a blow, with or without fracture of the nasal bones, or mere plethora of the system, nature endeavoring to find a spontaneous outlet for the redundant fluid. Young persons, of both sexes, are particularly prone to this discharge about the period of puberty. Occasionally the flow is vicarious of the menstrual flux. The amount of bleeding varies from a few drachms to a number of ounces. In the latter case, and especially when the discharge is of frequent recurrence, excessive debility, and even loss of life, may be the result, as I have witnessed in not less than three instances. The blood generally proceeds from one nostril only; very rarely from both. In the milder cases, it probably emanates in great measure, if not entirely, from the inferior portion of the nasal septum.

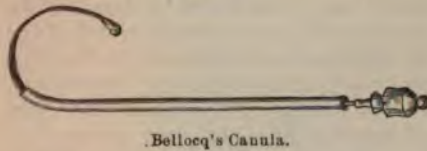
In the more ordinary forms of nasal hemorrhage, little or no treatment is usually necessary; nor need anything be done when the discharge is vicarious of the menses. It is only, as a general rule, when the bleeding is profuse, or when, if slight, it recurs so frequently as to induce debility, that an attempt should be made to suppress it. The most suitable remedies, in addition to elevation of the head and shoulders, and perfect quietude of mind and body, are acetate of lead and morphia, tannate of iron, and fluid extract of ergot, given in liberal quantities, more or less frequently repeated, according to the urgency of the case. The heart's action must be promptly tranquillized with morphia and aconite. Pounded ice should be applied to the nape of the neck; and pieces of ice inserted into the nostrils often produce a very happy effect. Hot mustard foot-baths are frequently of great benefit, especially when there is coldness of the extremities. Dover's powder, in large doses, should be prescribed when there is dryness of the skin. General bleeding is indicated only when the hemorrhage is connected with, or dependent upon, a plethoric state of the system. In obstinate cases, blisters applied to the back of the neck will be serviceable as counter-irritants. Tincture of chloride of iron, with quinine, milk punch, and beef essence, will be needed to increase the quantity and quality of the blood when the hemorrhage has been unusually copious. An injection of a strong solution of sub-sulphate of iron sometimes promptly arrests the bleeding. Compression of the nostrils occasionally answers a good purpose, the fingers being retained until the blood is thoroughly coagulated, the head being strongly inclined forwards during the operation, and care taken that the patient do not blow his nose, lest the clots be prematurely detached, and the bleeding break forth afresh.

When these measures fail, or when as much blood has already been lost as the system can bear, direct interference by obstructive means is required. The patient being supported upon the edge of a bed, in the semierect posture, a double wire, very thin and flexible, and composed either of silver or iron, is passed along the floor of the nostril into the fauces, where it is seized with the finger introduced into the mouth. A strong, double ligature, tied over a piece of soft sponge, or a roll of cotton, charpie, or patent lint, is then secured to the loop, and drawn up into the nose by retracting the wire. The finger, being still in the mouth, assists in carrying the tampon round the palate and in adjusting it in the posterior naris. The wire is now detached, and the operation completed by tying the ends of the thread over another plug in front. Both outlets being thus effectually occluded, the hemorrhage must necessarily cease as soon as the nasal cavity is filled with blood, which thus serves to compress and control the bleeding vessels. The parts are not disturbed until the end of the second or third day, when the tampons are removed, and the nasal cavity washed out with some mildly astringent lotion, introduced with the syringe.

When no wire is at hand, the plugging may be performed with a gum-elastic catheter, a piece of whalebone, or a stick of wood; in fact, with almost anything.

The best contrivance, however, of all, is that represented in fig. 271, and known as Bellocq's canula. It consists of a silver tube, nearly straight, about six

Fig. 271.

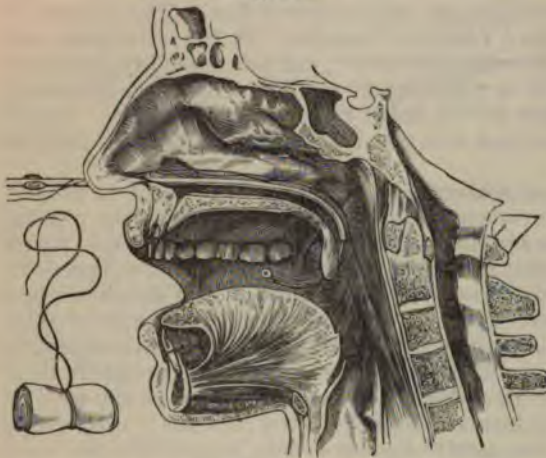


Bellocq's Canula.

inches long, containing a movable rod nearly of the same length, with a steel spring surmounted by a silver knob, with a hole in the centre for the attachment of the ligature which holds the posterior tampon. The instrument is one of the most perfect imaginable, and should find a place in every surgeon's armamentarium. Fig. 272 exhibits the manner of applying it.

Sometimes the hemorrhage may be promptly and effectually arrested by plugging the nostril with a piece of sheep's intestine, filled with water, the fluid being intro-

Fig. 272.



Plugging of the Nose.

duced after the insertion of the tube, so as to make firm and equal pressure upon the bleeding surfaces. This treatment, first suggested, I believe, by Mr. Green, of London, has the advantage of admitting of the frequent injection of cold water, until all disposition to hemorrhage has ceased. Garriel recommended, in 1850, with a similar view, a tube of caoutchouc, inserted into the nose, and filled by insufflation. By carrying the tube back into the fauces, it will form an effectual obturator for the posterior naris.

I have seen five fatal cases of epistaxis. In every one death was caused either by imperfect plugging of the nostrils, or because the operation was not

performed until the patient had become exhausted by the hemorrhage.

It is a matter of great moment that the plugs should not be retained too long, as they would be a source of irritation and mischief, provoking the formation of matter, which soon becomes excessively offensive, tainting the atmosphere and poisoning the system. I have seen several cases where, from this cause, the patient lost his life, being seized with a slow form of fever, attended with delirium, which nothing could arrest. In one of the cases there were marked symptoms of pyemia. To prevent these mishaps the plugs should be withdrawn at the end of forty-eight hours, and the nostrils well syringed with some mildly detergent and deodorizing lotion, when, if necessary, substitution should be effected. When there is much discharge, a daily renewal of the dressings may be proper. It is impossible to direct too earnest attention to this subject. The late Professor Colles, of Dublin, met with a case in which a plug in the posterior naris excited tetanus.

The removal of the plug may generally be easily effected by means of a female catheter or grooved director, passed along the floor of the nostril, a pair of polyp forceps being previously introduced into the mouth to seize the foreign body the moment it is detached. Such a precaution is eminently necessary; otherwise the plug, having lost its hold, might fall upon the epiglottis, and thus instantly produce suffocation.

Plugging of the posterior nares is sometimes advantageously practised as a means of preventing the escape of blood into the throat and larynx in operations on the nasal cavities, the maxillary sinus, and the superior jaw. The tampon should, of course, be removed as soon as the bleeding has ceased.

4. *Abscess.*—Two kinds of abscesses are liable to form in the nasal septum, the common and the syphilitic, the latter being by far the more frequent. The former is generally the result of external violence, as a blow or a fall, and is of a strictly phlegmonous nature, running its course rapidly, the local and constitutional symp-

toms being characterized by more or less severity, and the matter being of a thick consistence and of a yellow-greenish color. The treatment is by leeching and early evacuation, along with light diet and gentle purgation.

The syphilitic abscess generally occurs late in the tertiary stage of this affection, and is usually tardy in its development, although occasionally it proceeds so rapidly as to give it the character of an acute disease. The matter is sanious, irritating, fetid, and more or less abundant. The abscess generally takes its rise in a gummy tubercle, in the connective tissue beneath the mucous membrane, which is elevated in the form of a small bladder, closely simulating a gelatinoid polyp. Its formation is usually attended with a thin, watery discharge from the nose, and trouble in breathing. Pain of a throbbing character is sometimes present. The coexistence of the abscess with syphilis in other parts of the body usually determines the diagnosis. Early evacuation and iodide of potassium constitute the most important remedies. In case the matter has perforated the septum, an effort must be made to heal the ulcer with nitrate of silver and other suitable local means.

5. *Ulceration*.—Ulcers of the nose, chiefly of a strumous or syphilitic nature, are sufficiently common, and from their rebellious character and fetid discharge, are often a source of great annoyance, both to the patient and practitioner. Seated originally in the mucous membrane, they gradually extend in depth, until, in many cases, they involve all the component structures, cartilage and bone, as well as fibrous tissue. The disease generally commences high up in the nose, beyond the reach of the eye of the observer; but not unfrequently its first effects are displayed upon the inferior turbinated bone, or the nasal septum. In the strumous variety one side alone may suffer, whereas in the syphilitic nearly always both are implicated. Both forms are often met with in early life, and hence it is by no means always easy to distinguish them from each other. Perhaps, the most important diagnostic characters are that, in syphilitic ulceration, there is, ordinarily, greater derangement of the general health, more extensive involvement of structure, and more abundant discharge, than in the strumous variety. Useful information may also, commonly, be derived from the history of the case and the temperament of the patient, although the latter is frequently of negative value, as scrofula and syphilis may coexist.

The discharge attendant on this disease is noted for the intensity of its fetor, whence the term *ozæna*, by which it is generally designated. It is commonly of a thin, sanious nature, irritating, profuse, and easily aggravated by exposure to cold and other causes. During sleep it often descends into the fauces and the stomach, occasioning nausea and sometimes even vomiting. In the more aggravated forms of the affection large quantities of inspissated mucus pass off, or, collecting in the nasal cavities, form thick, brownish incrustations, which drop off every fourth, fifth, or sixth day, only to be succeeded by another crop. Portions of cartilage and bone, or even an entire bone, often die, and slough away. In syphilitic ulceration, more frequently than in the strumous, the ravages of the disease often extend to the proper bones of the nose and palate, and occasionally even to those of the face, eventuating in horrible and irremediable deformity.

The treatment of ulceration and *ozæna* must be regulated by the nature of the exciting cause, which should therefore always, if possible, be ascertained beforehand. It should not be forgotten that a bloody and fetid discharge from the nose may be occasioned merely by the presence of a foreign body, retained secretion, or disorder of the general health. Such cases are managed on general principles; they require no specific remedies. But it is otherwise when the disease is dependent upon a tainted state of the system. Here, a long course of treatment, involving the exercise of much patience on the part of the sufferer, and great skill on that of the surgeon, is usually necessary. When the strumous character of the disease is well settled, the different preparations of iodine, barium, and cod-liver oil are brought into requisition. If, on the contrary, it has been induced by syphilis, mercury and iodide of potassium should be employed, to an extent commensurate with the exigencies of the case. In general, there is no remedy which makes so rapid and decided an impression as local bleeding by means of a leech applied every fourth or fifth day directly to the inflamed surface. During the height of the morbid action, free purgation and antimonial and saline medicines may be demanded. Ordinarily, however, stimulants and tonics, and not depletory measures, are necessary, as is evident from the pallor of the countenance, and the emaciated condition of the frame.

To allay fetor, and assist in establishing healthy action in the affected parts, various lotions are employed. The best are weak solutions of chlorinated soda, permanganate of potassa, chloride of zinc, nitric acid, nitrate of silver, and sulphate of copper, thrown twice a day into the nostril with a large syringe, or, what is preferable, Thudichum's apparatus. The black and yellow washes, as they are termed, so useful in certain forms of syphilitic ulcers in other parts of the body, are objectionable in this, on account of their liability to descend into the stomach, and thus lead to pyalism. For many years past I have been in the habit of employing, with signal benefit, in both varieties of the disease under consideration, a solution of sulphate of copper and tannic acid, in the proportion of one-fourth of a grain of the former with three grains of the latter to the ounce of water. When there is much fetor, a small quantity of chlorinated soda may advantageously be added to the other ingredients. In old, obstinate cases, a rapid cure may sometimes be effected by washing out the nostril freely, twice a day, with a solution of chloride of zinc, in the proportion of ten to fifteen drops to eight ounces of water. A weak solution of common salt is sometimes very beneficial, as half an ounce to the quart of water. When the diseased spot can be reached, as when it is seated in the anterior and inferior part of the nose, nitrate of silver and sulphate of copper may be applied in substance, or the sore may be touched very lightly with dilute acid nitrate of mercury. Some of the milder unguents, as the citrine and calamine, often prove serviceable by softening the scabs, and promoting healthy granulation. When there is swelling, with pain or tenderness in the nose, leeching will be serviceable.

There can be no more serious error committed in the treatment of ozæna than the employment of irritating lotions and unguents. The sensibility of the mucous membrane of the nose is naturally very great, and it is often not a little heightened in disease. Hence, the best plan is always to begin the treatment with a very weak application, the strength being gradually increased as the cure progresses; and as one article becomes inert another should be substituted. If there be any decided smarting, or a sense of pain and tension in the frontal sinus, the remedy will be more likely to be prejudicial than beneficial, and should immediately be weakened.

6. *Necrosis*.—Necrosis of the turbinated bones and also of the vomer is sufficiently common as an effect of tertiary syphilis. The disease may be limited, or it may involve the whole of one of these pieces. The symptoms are muco-purulent discharge, more or less abundant, excessive fetor, and a feeling of weight and soreness in the nostril. The treatment consists of deodorizing and slightly detergent injections, with removal of the dead bone as soon as it is found to be sufficiently detached. When the whole turbinated bone is necrosed, it may be necessary to break or divide it, in order to facilitate extraction.

7. *Hypertrophy*.—Hypertrophy of the mucous membrane of the nose is observed chiefly in children and young persons of a weakly, strumous constitution. Its most common site is the anterior extremity of the inferior turbinated bone: it consists of an enlarged and thickened state of the mucous tissues, dependent upon a process of hypernutrition, along with effusion of sero-plastic matter. The subjacent bone occasionally participates in the disease, becoming soft, porous, and expanded. Upon looking into the nostril with the aid of a strong light, the part presents the appearance of a small tumor, of a scarlet color, and of a spongy consistence, with numerous little vessels ramifying over its surface. It is generally of slow development, and the only inconvenience which it produces is its mechanical obstruction, which is sometimes so great as to lead to considerable embarrassment of breathing in the corresponding cavity. Both nostrils occasionally suffer, although seldom in an equal degree. The only affection with which it is liable to be confounded is polyp, but from this it is always easily distinguished by its site, scarlet color, and fixedness. The disease may continue, with perhaps little change, for years, and finally disappear spontaneously. The remedies best adapted to its cure are purgatives, and the different preparations of iodine, especially the iodide of iron, with a leech occasionally to the part, and the application, twice a week, of the solid nitrate of silver. Punctures and astringent lotions are sometimes beneficial.

8. *Deviations of the Septum*.—The most important malformation of the nose, surgically considered, relates to its septum. It consists of a kind of lateral curvature of the cartilaginous portion of the septum, with or without hypertrophy of its anterior extremity. In consequence of this deviation, the corresponding cavity is diminished in size, and the opposite one proportionately enlarged. Cases occur in which

the obstruction, thus produced, amounts almost to complete occlusion, the patient being obliged to breathe nearly entirely through the unaffected nostril. The only remedy for this affection is excision of a portion of the offending septum, care being taken to avoid perforating it. The best instrument for performing the operation is a narrow, probe-pointed bistoury, with which the necessary slicing is safely and expeditiously executed. When the obstruction is seated at the very orifice of the nostril, a tolerably extensive dissection may be required in order to effect the desired object.

9. *Congenital Occlusion*.—Congenital imperforation of the nostrils is uncommon; much more so than that of the ear, anus, urethra, or vagina. The occlusion may be caused simply by a continuation of the integument, or by the presence both of skin and of fibrous tissue. In the former case, relief is sought by a cautious incision, and the subsequent use of the bougie; in the latter, by excision, provided the obstruction does not extend too far back, when it should be let alone.

10. *Calculi*.—Nasal calculi, technically termed rhinoliths, are very infrequent; they are usually situated in the inferior meatus, are of an irregular shape, and vary from the volume of a pea to that of a pigeon's egg. Their surface is rough, and they are of a black, gray, or brown color, their centre often consisting of some foreign body, as the root of a tooth, a bead, or a cherry-stone. Their composition is phosphate and carbonate of lime, cemented by animal matter. These calculi are usually solitary, but sometimes they are multiple, or form in each nostril. Their presence is productive of the usual symptoms of obstruction of the nose, with more or less discharge of a sanious and fetid character. When of considerable bulk, they may cause a good deal of pain and inflammation in the neighboring structures. Simple inspection of the nostril generally suffices to detect them; when this fails, a probe is introduced, which, on coming in contact with the extraneous body, produces a characteristic click, not unlike what results from the contact of a sound with a vesical calculus. Extraction is accomplished with a hook, bent probe, or polyp forceps; or, the attempt being unsuccessful, the concretion is pushed into the fauces, a finger being previously placed there to receive it. Sometimes expulsion is effected during a fit of sneezing. A body of this kind lies occasionally under the mucous membrane, and then requires the use of the knife for its liberation.

11. *Foreign Bodies*.—Various substances may find their way into the nasal cavities of children, being generally placed there as a matter of amusement. The most common of these are grains of corn, peas, beans, beads, pellets of paper, buttons, fruit-stones, rags, and pieces of ribbon. If allowed to remain for any length of time, they always induce inflammation, and sometimes even ulceration of the lining membrane, with more or less pain, and a sanious, fetid discharge. In a case reported by Dr. Hays, of this city, the substance, a glass button, was retained upwards of twenty years, keeping up constant irritation. Their ordinary site is the anterior portion of the nostril, between the turbinated bone and the nasal septum, where they are often firmly impacted, and consequently difficult of spontaneous extrusion. Should the child, or an inexperienced person, attempt extraction, as is too often the case, the foreign body will only be pushed farther in, and in this way it frequently passes entirely beyond the reach of the sight, being arrested, perhaps, pretty high up in the cavity, or forced against the floor of the inferior meatus.

Whatever the foreign body may be, it should always, for the reasons above mentioned, be extracted as speedily as possible. If the child is sufficiently old to co-operate with the surgeon, he is requested to take a pinch of snuff, and, during the effort of sneezing which is sure to follow, expulsion is often promptly effected, especially if care be taken at the same time to occlude the sound nostril by means of the finger. If the substance obstructs the passage completely, it may often be promptly dislodged by insufflation. For this purpose the unaffected nostril is closed by external pressure, when the surgeon blows forcibly with his own mouth into the mouth of the patient, the current of air thus established being sufficient to cause extrusion. In general, however, the removal of the foreign body is easily enough effected with a small, flexible, blunt, double hook, a probe bent at the end, or a piece of annealed wire, formed into a loop. The best instrument of all is the ear-pick, delineated at p. 328. The patient being in a strong light with the head inclined somewhat backwards, the instrument is carried obliquely upwards, on a line with the external nose, above and behind the foreign body, which is then extruded by a kind of jerking movement of the hand. The great fault usually committed by the surgeon, in his

attempts at extraction, is that he inclines the instrument too horizontally, whereby he is sure to push the intruder farther into the nostril.

In the American Journal of the Medical Sciences for April, 1860, Dr. W. S. King, of the Navy, gives an instance of the expulsion of a cherry-stone from the nose of a child during the action of an emetic, the mouth being tightly closed at the moment of emesis with a handkerchief.

When the extraneous substance is out of sight, it may be necessary to wash it away with a stream of water from a syringe, or to push it into the throat, and extract it through the mouth, as in a case communicated to me by Dr. William H. Pancoast. The patient, in stooping over a pincushion, accidentally ran a hairpin, two inches and a half in length, into the nose. The accident was followed by profuse bleeding, and, on expanding the nostril, it was barely possible to discern the point of the pin, which was immediately removed with a pair of forceps, aided by the index finger.

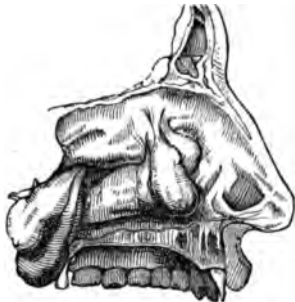
In a case mentioned to me by Dr. J. J. Moorman, the foreign body—a large bean, introduced a few days before and pushed far back into the nostril by the previous efforts at extraction—was propelled forward within reach of the forceps, by closing the mouth with the hand, so as to make the patient, a child two years old, breathe entirely through the nose.

Finally, it may be proper, in order to effect extraction, if the patient be very fractious and unruly, to administer chloroform; or, if this be objectionable, to secure his body with a stout apron, as in the operation for harelip.

12. *Polyps*.—The nose is a frequent seat of polyps, more so, in fact, than any other mucous cavity of the body. Numerous varieties of these morbid growths have been described by authors, but without any foundation in nature; for there are, in truth, only two, the gelatinoid and fibrous, which possess sufficiently distinctive characters to entitle them to separate consideration.

The *gelatinoid polyp*, fig. 273, resembles, as its name imports, a mass of jelly, or, more closely still, a common oyster. It is of a soft, spongy consistence, moist, somewhat translucent, and of a white, grayish, greenish, or grayish-yellow color.

Fig. 273.



Gelatinoid Polyp.

Its surface, which is generally smooth, or smooth at one point and lobulated at another, is covered with cylindrical epithelium, and nearly always presents a few small, straggling vessels, which thus serve to impart to it a peculiar striated appearance. In its shape, the tumor is ordinarily somewhat pyriform, its attachment being by a narrow pedicle, while the broad, bulbous portion hangs downwards and forwards into the nostril. It almost constantly takes its rise from the superior turbinated bone, and often exists in great numbers, although occasionally it is solitary. In a case under my charge a few years ago, I counted upwards of twenty separate tumors, from the size of a small pea up to that of a hazelnut. When carefully examined, it is observed to consist of a delicate cellulo-

fibrous tissue, the interspaces of which are occupied by a sero-albuminous fluid, much of which drains off on puncturing the investing membrane. Owing to this peculiarity of structure, the tumor is of a hygrometric character, expanding in damp, foggy weather, and shrinking in dry. It also generally exhibits a distinct adenoid structure, the mucous glands being greatly enlarged and increased in number. It is devoid of sensibility, breaks easily under pressure, is most common in persons after the age of forty, and frequently exists simultaneously in both nostrils. Its volume is usually diminutive. A polyp of this kind occasionally contains fibro-cartilaginous concretions, as in a specimen in my private collection, taken from an elderly gentleman. Very recently I removed, from the right nostril of a middle-aged woman, a patient at the College Clinic, a gelatinoid polyp, which, upon inspection, was found to have a small osseous incrustation upon its surface. When a growth of this kind projects beyond the anterior naris, the exposed part shrivels, and assumes a reddish, brownish, or purplish tint.

The *fibrous polyp*, of which the annexed cut, fig. 274, from a specimen in my collection, exhibits a well-marked example, occurs at nearly every period of life; I have seen it in children under fourteen years of age, in adults, and in old persons. More rare than the gelatinoid variety, it generally exists singly, is very prone to reappear

after removal, and often displays a malignant tendency, when it will generally be found that it has assumed the type of fibrous sarcoma. It is ordinarily attached by a broad base to the superior turbinated bone, but occasionally it springs from the septum, floor, or wall of the nose. In most of the cases that have fallen under my

Fig. 274.



Fibrous Polyp.

notice, it was situated in the posterior part of the nostril, so as to be distinctly perceptible in the throat. Both sides may suffer simultaneously, but this is uncommon. The structure of the tumor is characteristic; it is composed of fibres, of a white, glistening color, exceedingly firm and tough, closely knit together, and most intricately arranged. Interspersed among these fibres are numerous vessels, both arterial and venous, the walls of which are very brittle, and, therefore, liable to give way under the most trivial accidents. Owing to this circumstance, this form of polyp is the seat of frequent, and, at times, profuse hemorrhages. For the same reason, it is always, in its recent state, of a dark red, purple, or modena color. Calcareous deposits occasionally occur in its substance, and now and then portions undergo the cartilaginous or osseous degeneration. Permitted to pursue its course, the tumor may acquire an enormous bulk, descending into the throat, protruding externally, and pressing against the walls of the nasal and oral cavities in every direction. At this stage of the disease, the features are often frightfully distorted, presenting that peculiar appearance, seen in fig 275, denominated "frog-face."

A fibrous polyp, the history of which has been admirably elucidated by Flaubert, Michaux, Huguier, Nélaton, Robert, Maisonneuve, Giraldès, Massé, and other French surgeons, occasionally springs from the base of the skull, the petro-occipital suture, the inner surface of the great wing of the sphenoid bone, or even from the upper part of the spinal column, projecting, as it advances, into the nose and pharynx, and hence called the *naso-pharyngeal* polyp. It is of a very hard, dense texture, of a bluish, purplish, or livid color, and capable of acquiring a large bulk, its growth being rapid and uncontrollable by medicine.

Fig. 275.



Frog-face; the Polyp causing much Deformity.

When extirpated, it is apt to return, although now and then the operation is followed by permanent relief. A few instances are recorded of a spontaneous cure by sloughing. The tumor is usually attached by a broad base, closely identified with the periosteum of the part from which it springs. In its progress, it may extend down into the larynx, or, separating the muscles of the pharynx, pass into the zygomatic fossa and the face, although such an occurrence is extremely uncommon. The disease may occur at any period of life, but is by far most common in young subjects, between the fifteenth and twenty-fifth years. I have met with it very often, but have never witnessed it in the female, and I find that in most of the recorded cases the subjects of it were males. These tumors frequently exhibit, on minute examination, all the characteristic features of fibrous, or even pure spindle-celled, sarcoma, when their clinical history differs from that of the fibrous polyp in their more rapid growth, their softer consistence, their greater vascularity, and their disposition to perforate the skull. Examples of the latter occurrence have been recorded by Huguier, Deguise, Langenbeck, O. Weber, and other surgeons.

The *symptoms* of polyp are chiefly of a mechanical character, as in obstruction of the nose from any other cause. The first intimation which the patient ordinarily has of the disease is a sense of fullness and weight in one of the nostrils; he feels as if there were some fleshy substance in it, interfering with the transmission of air, and, as a necessary consequence, he makes frequent and abortive efforts to clear his nose, using his handkerchief, perhaps, every half hour. Gradually he observes some discharge, at first of a mucous, then of a purulent, and finally of a sanious character, fetid, and profuse. The voice is generally nasal, indistinct, and even snuffing; the sleep is embarrassed, and attended with loud snoring, the head being thrown back as in enlargement of the tonsils; the nose is blown with difficulty, and, during every effort of the kind, most of the contents of the nostril are forcibly projected into the fauces; the sense of smell is materially impaired; and eventually, as the growth spreads, the affected cavity is completely deprived of its functions. At this advanced stage of the disease, the patient is occasionally annoyed by lachrymation, partial deafness, and slight dizziness from the pressure of the tumor, respectively, upon the nasal duct, the Eustachian tube, and the jugular veins.

The symptoms above enumerated are, unfortunately, not characteristic; they may be, and often are, simulated by other affections. Thus, the person may labor under enlargement of one of the turbinated bones, hypertrophy of the mucous membrane, malposition of the nasal septum, or malignant disease, either of the nose itself, or of the maxillary sinus; or, finally, there may be a foreign body in the nose, causing serious obstruction, and profuse, sanious, and fetid discharge. A remarkable case has been recorded by Cruveilhier, in which a fibroma of the sheath of the second branch of the fifth pair of nerves made its way into the nostril through the sphenopalatine foramen, and was mistaken for a polyp. Attempts at evulsion were followed by death from meningitis. To make sure of the diagnosis, the polyp must be seen or felt. Protrusion at either opening of the nose at once decides the matter; but, in the absence of this, a careful inspection is made with the speculum, in a strong light, with the head inclined backwards; a grooved director is used, if necessary, to move the tumor about, and determine its size, consistence, and point of attachment. If the tumor is covered with mucus, clearance is first effected by blowing the nose, or, this failing, by means of a pellet of cotton wrapped around the end of a probe. When the polyp lies far back, it may project into the fauces, and thus satisfactorily reveal its character; should it not yet have descended, the index finger is introduced into the mouth, and carefully carried around the velum of the palate.

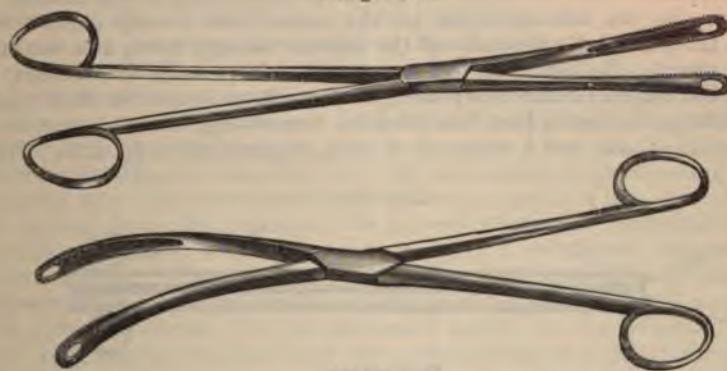
There are several circumstances which generally serve to distinguish a gelatinoid from a fibroid polyp. In the first place, they differ essentially in their complexion; the former being always white, like an oyster, a lump of mucus, or a mass of jelly, while the latter is of a deep red, purple, or modena color. Secondly, the gelatinoid polyp is generally smaller, and, consequently, its existence less marked in dry than in damp weather, which is not the case with the fibroid tumor, which is not affected by atmospheric vicissitudes of any kind. Thirdly, the discharge is always less profuse, less offensive, and less bloody in the gelatinoid than in the other form of the disease; and, finally, there is rarely any involvement of the general health in the former affection, while in the latter it seldom escapes, especially in the advanced stages. Moreover, the fibroid polyp usually grows much more rapidly than the

other, and has a much greater tendency to encroach injuriously and disfiguringly upon the surrounding structures.

Of the *causes* of nasal polyps nothing is known. The disease is often ascribed to the effects of external injury, the employment of snuff, the habit of picking the nose, and the irritation of decayed teeth; but it is very questionable whether it is ever induced in this way. Males suffer from it much oftener than females. Polyps may attain a large size in a few months; or, after having made some progress, remain stationary for an indefinite period. I have seen the gelatinoid tumor attain, in less than a year, the volume of a hen's egg.

Treatment.—There is no doubt that a gelatinoid polyp of the nose is occasionally amenable to local remedies; but the cures thus effected are uncommon, and cannot serve as rules of practice, even in ordinary cases. At one time a good deal of confidence was placed in the use of finely pulverized bloodroot, as a snuff, in the treatment of this affection; the insufflation of tannic acid has also been recommended; and, in 1859, Dr. J. H. Reeder, of Illinois, published the particulars of

Fig. 276.

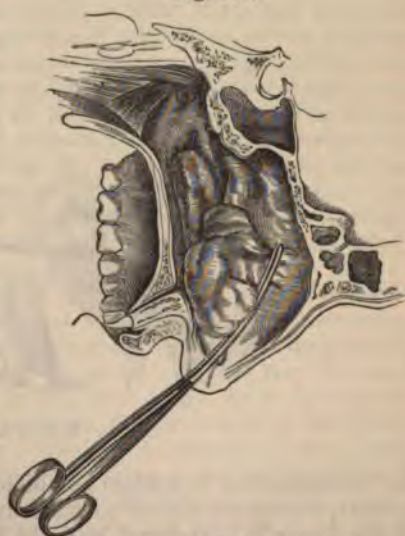


Polyp-forceps.

two cases in which prompt cures were obtained by strong injections of the tincture of chloride of iron, conjoined with the application of a piece of sponge moistened with a solution of this article to the cavity of the nose. The best plan, however, generally is not to waste any time in this way, but to proceed at once to the removal of the tumor. Fortunately, this is usually easily effected by torsion with the forceps. Very suitable instruments for this purpose are represented in the adjoining sketches, fig. 276. They are very light and slender, being seven inches and a half in length, and provided with large rings. The blades, which are nearly three inches long, are fenestrated, and grooved internally, with well serrated margins. The great fault of the common polyp-forceps is that they are too short and clumsy. When the tumor is situated in the upper and back part of the nose, a curved instrument may sometimes be advantageously employed. The mode of applying the forceps is represented in fig. 277.

The patient being seated upon a chair, in a strong light, with the head supported upon the breast of an assistant, the operator introduces the forceps as high as the origin of the tumor, which is then seized by expanding the blades over its pedicle, and twisted off by turning the instrument several times very gently upon its axis. No pulling or traction is permissible, lest injury should be inflicted upon the mucous membrane, or the turbi-

Fig. 277.



Mode of Extracting a Nasal Polyp.

nated bone be torn away. If the first attempt is unsuccessful, or if a part of the polyp is broken off, the instrument is reinserted, again and again, until the object is accomplished, not a particle of the growth being left behind, it being desirable, if possible, to effect complete clearance at one sitting. When there are several tumors, they should all be dealt with in a similar manner. The blood which flows during the operation has a tendency to conceal the polyp, but it is easily dislodged by blowing the nose, the sound nostril being compressed, to render the effort more effective. If riddance is impracticable in this wise, a stream of cold water, or of vinegar and water, is thrown up with a large syringe. It is rarely necessary to suspend the operation on account of hemorrhage; the bleeding is usually slight, and nearly always ceases spontaneously in a few minutes. When it threatens to be copious and persistent, plugging of the nose may be proper.

When the tumor is situated far back in the nose, or hangs down into the fauces, it may occasionally be broken off with the index-finger, introduced into the mouth, and carried round the palate. In this way I promptly succeeded in removing, not long ago, a large gelatinoid polyp from a youth of seventeen; but I have no idea that the procedure would answer in the fibrous polyp, or even in a gelatinoid one with a broad base. In the case adverted to, the tumor had a very narrow footstalk, attached to the posterior extremity of the inferior spongy bone, and was, therefore, easily torn away. Nothing can be accomplished here with the forceps, however ingeniously curved and dexterously used, as there is no space for their application. When, therefore, the means just described are unavailing, removal must be effected with the double canula and a stout silver wire, represented in fig. 278. The instru-

Fig. 278.



Double Canula.

ment, which is four inches and a half in length, is conveyed along the floor of the nostril as far as the fauces, when the loop of the wire is properly expanded, and passed around the neck of the tumor, as near as possible to its origin. The ends of wire are then firmly but cautiously pulled, and secured to the shoulders of the canula. The annexed cut, fig. 279, exhibits the mode of applying the instrument.

Fig. 279.



Mode of Ligating a Nasal Polyp.

The strangulation is seldom completed under three or four days, during which it is necessary to tighten the wire occasionally. When the polyp is nearly ready to drop off, the finger is introduced into the fauces, and the canula rotated on its axis, to promote the separation, lest, taking place during sleep, the tumor pass into the wind-

pipe or œsophagus. In the gelatinoid form of the disease, the safest and most expeditious plan is to twist off the polyp the moment it is fairly embraced with the wire. I have occasionally succeeded in removing a fibrous polyp, when situated far back on the floor of the nose, or at the posterior naris, with an instrument shaped like a common chisel, about two lines in width, and beveled off to a moderately sharp edge on one side of its extremity. The growth is easily scraped away from its connections, especially if counter-pressure be applied to it with the index finger in the fauces. The operation, however, is liable to be attended with a good deal of bleeding, rendering it occasionally necessary to plug the nose.

Fibrous polyps may be removed more rapidly than by strangulation, and, probably, with equal safety as regards the occurrence of hemorrhage, either by the wire *écraseur* or the galvanic noose of Middeldorpf. The latter measure, however, is rarely applicable in private practice.

When the fibrous polyp is of extraordinary bulk, and quite inaccessible by the means now pointed out, its removal can be effected only by the knife, or the knife and saw. When the disease is carcinomatous, no operation should be attempted, not even with a view to temporary alleviation; much blood will be likely to be lost, the manipulations will be tedious and painful, and the patient may die on the table. Under opposite circumstances, the operation is performed at all hazards, and with a prospect of a favorable issue. An incision, in the form of an inverted **L**, is made along the junction of the nasal and maxillary bones, commencing immediately below the lachrymal sac, and terminating a little below the level of the nostril, the flaps being dissected up, and held asunder.

No particular treatment is required after the more common operations of this kind; there is usually very little inflammation or discharge, and in a few days the patient is able to go out about his business. To prevent relapse, it is customary to inject the nose once a day with some astringent wash, as a solution of nitrate of silver, zinc, copper, or alum. The practice may, however, in general, be advantageously dispensed with; it is only when there is evidence of persistent morbid action that it is likely to prove beneficial. In the gelatinoid variety of the affection, where the tendency to regeneration is sometimes most remarkable, and also in the gregarious form of this disease, I have occasionally broken off as much as one-half and even two-thirds of the implicated spongy bone, believing that this procedure was greatly preferable to the frequent repetition of the ordinary operation.

For the removal of *naso-pharyngeal* polyps two distinct operations may be practised; one of which, originally proposed by Nélaton, consists in the division of the soft and hard palate, and the other, devised by Langenbeck, in the temporal depression of the upper jaw. Excision of the entire maxilla, first executed by Syme in 1832, and at one time recognized as a justifiable procedure, is no longer deemed advisable. The method of Nélaton is more especially applicable when the tumor is situated partly in the nose and partly in the pharynx, or when it springs from the middle of the base of the skull, the superior portion of the spine, or the internal surface of the pterygoid process, at the same time sending a prolongation into the pharynx. It is executed by dividing, first, the soft palate in its whole length, and then, by means of the saw and pliers, so much of the hard palate as may be necessary to afford complete access to the parts, the mucous membrane and periosteum having previously been raised from the bone. When the tumor is not very bulky, the operation may be limited to the soft palate, as advocated by Mandé, of Avignon, in 1747, and modified by Maisonneuve, in 1859, by leaving the uvula intact. Through this opening, denominated the "palatine button hole," the base of the growth is encircled by a loop of wire and removed by crushing.

Depression of the jaw, as originally practised by Langenbeck, in 1859, is required when the polyp springs from the petrous portion of the temporal bone, the petro-occipital suture, or the borders of the foramina lacera, thus rendering it inaccessible by the mouth. When the tumor is of unusual bulk, or when it has very firm and extensive attachments, it may be necessary to invade both bones, as in the remarkable case of Dr. Cheever, of Boston. In the operation, as performed by the Berlin Professor, a slightly crescentic incision with the convexity downwards is made from the ala of the nose along the lower border of the malar bone as far as the middle of the zygoma. A second incision, beginning at the centre of the root of the nose, is carried along the inferior margin of the orbit, across the frontal process of the malar bone, and joins the other at an obtuse angle. Leaving the integument intact, the

To allay fetor, and assist in establishing healthy action in the affected parts, various lotions are employed. The best are weak solutions of chlorinated soda, permanganate of potassa, chloride of zinc, nitric acid, nitrate of silver, and sulphate of copper, thrown twice a day into the nostril with a large syringe, or, what is preferable, Thudichum's apparatus. The black and yellow washes, as they are termed, so useful in certain forms of syphilitic ulcers in other parts of the body, are objectionable in this, on account of their liability to descend into the stomach, and thus lead to pyalism. For many years past I have been in the habit of employing, with signal benefit, in both varieties of the disease under consideration, a solution of sulphate of copper and tannic acid, in the proportion of one-fourth of a grain of the former with three grains of the latter to the ounce of water. When there is much fetor, a small quantity of chlorinated soda may advantageously be added to the other ingredients. In old, obstinate cases, a rapid cure may sometimes be effected by washing out the nostril freely, twice a day, with a solution of chloride of zinc, in the proportion of ten to fifteen drops to eight ounces of water. A weak solution of common salt is sometimes very beneficial, as half an ounce to the quart of water. When the diseased spot can be reached, as when it is seated in the anterior and inferior part of the nose, nitrate of silver and sulphate of copper may be applied in substance, or the sore may be touched very lightly with dilute acid nitrate of mercury. Some of the milder unguents, as the citrine and calamine, often prove serviceable by softening the scabs, and promoting healthy granulation. When there is swelling, with pain or tenderness in the nose, leeching will be serviceable.

There can be no more serious error committed in the treatment of *ozæna* than the employment of irritating lotions and unguents. The sensibility of the mucous membrane of the nose is naturally very great, and it is often not a little heightened in disease. Hence, the best plan is always to begin the treatment with a very weak application, the strength being gradually increased as the cure progresses; and as one article becomes inert another should be substituted. If there be any decided smarting, or a sense of pain and tension in the frontal sinus, the remedy will be more likely to be prejudicial than beneficial, and should immediately be weakened.

6. *Necrosis*.—Necrosis of the turbinated bones and also of the vomer is sufficiently common as an effect of tertiary syphilis. The disease may be limited, or it may involve the whole of one of these pieces. The symptoms are muco-purulent discharge, more or less abundant, excessive fetor, and a feeling of weight and soreness in the nostril. The treatment consists of deodorizing and slightly detergent injections, with removal of the dead bone as soon as it is found to be sufficiently detached. When the whole turbinated bone is necrosed, it may be necessary to break or divide it, in order to facilitate extraction.

7. *Hypertrophy*.—Hypertrophy of the mucous membrane of the nose is observed chiefly in children and young persons of a weakly, strumous constitution. Its most common site is the anterior extremity of the inferior turbinated bone: it consists of an enlarged and thickened state of the mucous tissues, dependent upon a process of hypernutrition, along with effusion of sero-plastic matter. The subjacent bone occasionally participates in the disease, becoming soft, porous, and expanded. Upon looking into the nostril with the aid of a strong light, the part presents the appearance of a small tumor, of a scarlet color, and of a spongy consistence, with numerous little vessels ramifying over its surface. It is generally of slow development, and the only inconvenience which it produces is its mechanical obstruction, which is sometimes so great as to lead to considerable embarrassment of breathing in the corresponding cavity. Both nostrils occasionally suffer, although seldom in an equal degree. The only affection with which it is liable to be confounded is polyp, but from this it is always easily distinguished by its site, scarlet color, and fixedness. The disease may continue, with perhaps little change, for years, and finally disappear spontaneously. The remedies best adapted to its cure are purgatives, and the different preparations of iodine, especially the iodide of iron, with a leech occasionally to the part, and the application, twice a week, of the solid nitrate of silver. Punctures and astringent lotions are sometimes beneficial.

8. *Deviations of the Septum*.—The most important malformation of the nose, surgically considered, relates to its septum. It consists of a kind of lateral curvature of the cartilaginous portion of the septum, with or without hypertrophy of its anterior extremity. In consequence of this deviation, the corresponding cavity is diminished in size, and the opposite one proportionately enlarged. Cases occur in which

the obstruction, thus produced, amounts almost to complete occlusion, the patient being obliged to breathe nearly entirely through the unaffected nostril. The only remedy for this affection is excision of a portion of the offending septum, care being taken to avoid perforating it. The best instrument for performing the operation is a narrow, probe-pointed bistoury, with which the necessary slicing is safely and expeditiously executed. When the obstruction is seated at the very orifice of the nostril, a tolerably extensive dissection may be required in order to effect the desired object.

9. *Congenital Occlusion*.—Congenital imperforation of the nostrils is uncommon; much more so than that of the ear, anus, urethra, or vagina. The occlusion may be caused simply by a continuation of the integument, or by the presence both of skin and of fibrous tissue. In the former case, relief is sought by a cautious incision, and the subsequent use of the bougie; in the latter, by excision, provided the obstruction does not extend too far back, when it should be let alone.

10. *Calculi*.—Nasal calculi, technically termed rhinoliths, are very infrequent; they are usually situated in the inferior meatus, are of an irregular shape, and vary from the volume of a pea to that of a pigeon's egg. Their surface is rough, and they are of a black, gray, or brown color, their centre often consisting of some foreign body, as the root of a tooth, a bead, or a cherry-stone. Their composition is phosphate and carbonate of lime, cemented by animal matter. These calculi are usually solitary, but sometimes they are multiple, or form in each nostril. Their presence is productive of the usual symptoms of obstruction of the nose, with more or less discharge of a sanious and fetid character. When of considerable bulk, they may cause a good deal of pain and inflammation in the neighboring structures. Simple inspection of the nostril generally suffices to detect them; when this fails, a probe is introduced, which, on coming in contact with the extraneous body, produces a characteristic click, not unlike what results from the contact of a sound with a vesical calculus. Extraction is accomplished with a hook, bent probe, or polyp forceps; or, the attempt being unsuccessful, the concretion is pushed into the fauces, a finger being previously placed there to receive it. Sometimes expulsion is effected during a fit of sneezing. A body of this kind lies occasionally under the mucous membrane, and then requires the use of the knife for its liberation.

11. *Foreign Bodies*.—Various substances may find their way into the nasal cavities of children, being generally placed there as a matter of amusement. The most common of these are grains of corn, peas, beans, beads, pellets of paper, buttons, fruit-stones, rags, and pieces of ribbon. If allowed to remain for any length of time, they always induce inflammation, and sometimes even ulceration of the lining membrane, with more or less pain, and a sanious, fetid discharge. In a case reported by Dr. Hays, of this city, the substance, a glass button, was retained upwards of twenty years, keeping up constant irritation. Their ordinary site is the anterior portion of the nostril, between the turbinated bone and the nasal septum, where they are often firmly impacted, and consequently difficult of spontaneous extrusion. Should the child, or an inexperienced person, attempt extraction, as is too often the case, the foreign body will only be pushed farther in, and in this way it frequently passes entirely beyond the reach of the sight, being arrested, perhaps, pretty high up in the cavity, or forced against the floor of the inferior meatus.

Whatever the foreign body may be, it should always, for the reasons above mentioned, be extracted as speedily as possible. If the child is sufficiently old to co-operate with the surgeon, he is requested to take a pinch of snuff, and, during the effort of sneezing which is sure to follow, expulsion is often promptly effected, especially if care be taken at the same time to occlude the sound nostril by means of the finger. If the substance obstructs the passage completely, it may often be promptly dislodged by insufflation. For this purpose the unaffected nostril is closed by external pressure, when the surgeon blows forcibly with his own mouth into the mouth of the patient, the current of air thus established being sufficient to cause extrusion. In general, however, the removal of the foreign body is easily enough effected with a small, flexible, blunt, double hook, a probe bent at the end, or a piece of annealed wire, formed into a loop. The best instrument of all is the ear-pick, delineated at p. 328. The patient being in a strong light with the head inclined somewhat backwards, the instrument is carried obliquely upwards, on a line with the external nose, above and behind the foreign body, which is then extruded by a kind of jerking movement of the hand. The great fault usually committed by the surgeon, in his

attempts at extraction, is that he inclines the instrument too horizontally, whereby he is sure to push the intruder farther into the nostril.

In the *American Journal of the Medical Sciences* for April, 1860, Dr. W. S. King, of the Navy, gives an instance of the expulsion of a cherry-stone from the nose of a child during the action of an emetic, the mouth being tightly closed at the moment of emesis with a handkerchief.

When the extraneous substance is out of sight, it may be necessary to wash it away with a stream of water from a syringe, or to push it into the throat, and extract it through the mouth, as in a case communicated to me by Dr. William H. Pancoast. The patient, in stooping over a pincushion, accidentally ran a hairpin, two inches and a half in length, into the nose. The accident was followed by profuse bleeding, and, on expanding the nostril, it was barely possible to discern the point of the pin, which was immediately removed with a pair of forceps, aided by the index finger.

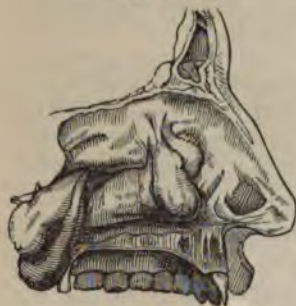
In a case mentioned to me by Dr. J. J. Moorman, the foreign body—a large bean, introduced a few days before and pushed far back into the nostril by the previous efforts at extraction—was propelled forward within reach of the forceps, by closing the mouth with the hand, so as to make the patient, a child two years old, breathe entirely through the nose.

Finally, it may be proper, in order to effect extraction, if the patient be very fractious and unruly, to administer chloroform; or, if this be objectionable, to secure his body with a stout apron, as in the operation for harelip.

12. *Polyps*.—The nose is a frequent seat of polyps, more so, in fact, than any other mucous cavity of the body. Numerous varieties of these morbid growths have been described by authors, but without any foundation in nature; for there are, in truth, only two, the gelatinoid and fibrous, which possess sufficiently distinctive characters to entitle them to separate consideration.

The *gelatinoid polyp*, fig. 273, resembles, as its name imports, a mass of jelly, or, more closely still, a common oyster. It is of a soft, spongy consistence, moist, somewhat translucent, and of a white, grayish, greenish, or grayish-yellow color.

Fig. 273.



Gelatinoid Polyp.

Its surface, which is generally smooth, or smooth at one point and lobulated at another, is covered with cylindrical epithelium, and nearly always presents a few small, straggling vessels, which thus serve to impart to it a peculiar striated appearance. In its shape, the tumor is ordinarily somewhat pyriform, its attachment being by a narrow pedicle, while the broad, bulbous portion hangs downwards and forwards into the nostril. It almost constantly takes its rise from the superior turbinated bone, and often exists in great numbers, although occasionally it is solitary. In a case under my charge a few years ago, I counted upwards of twenty separate tumors, from the size of a small pea up to that of a hazelnut. When carefully examined, it is observed to consist of a delicate cellulo-

fibrous tissue, the interspaces of which are occupied by a sero-albuminous fluid, much of which drains off on puncturing the investing membrane. Owing to this peculiarity of structure, the tumor is of a hygrometric character, expanding in damp, foggy weather, and shrinking in dry. It also generally exhibits a distinct adenoid structure, the mucous glands being greatly enlarged and increased in number. It is devoid of sensibility, breaks easily under pressure, is most common in persons after the age of forty, and frequently exists simultaneously in both nostrils. Its volume is usually diminutive. A polyp of this kind occasionally contains fibro-cartilaginous concretions, as in a specimen in my private collection, taken from an elderly gentleman. Very recently I removed, from the right nostril of a middle-aged woman, a patient at the College Clinic, a gelatinoid polyp, which, upon inspection, was found to have a small osseous incrustation upon its surface. When a growth of this kind projects beyond the anterior naris, the exposed part shrivels, and assumes a reddish, brownish, or purplish tint.

The *fibrous polyp*, of which the annexed cut, fig. 274, from a specimen in my collection, exhibits a well-marked example, occurs at nearly every period of life; I have seen it in children under fourteen years of age, in adults, and in old persons. More rare than the gelatinoid variety, it generally exists singly, is very prone to reappear

after removal, and often displays a malignant tendency, when it will generally be found that it has assumed the type of fibrous sarcoma. It is ordinarily attached by a broad base to the superior turbinated bone, but occasionally it springs from the septum, floor, or wall of the nose. In most of the cases that have fallen under my

Fig. 274.



Fibrous Polyp.

notice, it was situated in the posterior part of the nostril, so as to be distinctly perceptible in the throat. Both sides may suffer simultaneously, but this is uncommon. The structure of the tumor is characteristic; it is composed of fibres, of a white, glistening color, exceedingly firm and tough, closely knit together, and most intricately arranged. Interspersed among these fibres are numerous vessels, both arterial and venous, the walls of which are very brittle, and, therefore, liable to give way under the most trivial accidents.

Owing to this circumstance, this form of polyp is the seat of frequent, and, at times, profuse hemorrhages. For the same reason, it is always, in its recent state, of a dark red, purple, or modena color. Calcareous deposits occasionally occur in its substance, and now and then portions undergo the cartilaginous or osseous degeneration. Permitted to pursue its course, the tumor may acquire an enormous bulk, descending into the throat, protruding externally, and pressing against the walls of the nasal and oral cavities in every direction. At this stage of the disease, the features are often frightfully distorted, presenting that peculiar appearance, seen in fig 275, denominated "frog-face."

A fibrous polyp, the history of which has been admirably elucidated by Flaubert, Michaux, Huguier, Nélaton, Robert, Maisonneuve, Giraldès, Massé, and other French surgeons, occasionally springs from the base of the skull, the petro-occipital suture, the inner surface of the great wing of the sphenoid bone, or even from the upper part of the spinal column, projecting, as it

advances, into the nose and pharynx, and hence called the *naso-pharyngeal* polyp. It is of a very hard, dense texture, of a bluish, purplish, or livid color, and capable of acquiring a large bulk, its growth being rapid and uncontrollable by medicine.

Fig. 275.



Frog-face; the Polyps Causing much Deformity.

When extirpated, it is apt to return, although now and then the operation is followed by permanent relief. A few instances are recorded of a spontaneous cure by sloughing. The tumor is usually attached by a broad base, closely identified with the periosteum of the part from which it springs. In its progress, it may extend down into the larynx, or, separating the muscles of the pharynx, pass into the zygomatic fossa and the face, although such an occurrence is extremely uncommon. The disease may occur at any period of life, but is by far most common in young subjects, between the fifteenth and twenty-fifth years. I have met with it very often, but have never witnessed it in the female, and I find that in most of the recorded cases the subjects of it were males. These tumors frequently exhibit, on minute examination, all the characteristic features of fibrous, or even pure spindle-celled, sarcoma, when their clinical history differs from that of the fibrous polyp in their more rapid growth, their softer consistence, their greater vascularity, and their disposition to perforate the skull. Examples of the latter occurrence have been recorded by Huguier, Deguise, Langenbeck, O. Weber, and other surgeons.

The *symptoms* of polyp are chiefly of a mechanical character, as in obstruction of the nose from any other cause. The first intimation which the patient ordinarily has of the disease is a sense of fullness and weight in one of the nostrils; he feels as if there were some fleshy substance in it, interfering with the transmission of air, and, as a necessary consequence, he makes frequent and abortive efforts to clear his nose, using his handkerchief, perhaps, every half hour. Gradually he observes some discharge, at first of a mucous, then of a purulent, and finally of a sanious character, fetid, and profuse. The voice is generally nasal, indistinct, and even snuffling; the sleep is embarrassed, and attended with loud snoring, the head being thrown back as in enlargement of the tonsils; the nose is blown with difficulty, and, during every effort of the kind, most of the contents of the nostril are forcibly projected into the fauces; the sense of smell is materially impaired; and eventually, as the growth spreads, the affected cavity is completely deprived of its functions. At this advanced stage of the disease, the patient is occasionally annoyed by lachrymation, partial deafness, and slight dizziness from the pressure of the tumor, respectively, upon the nasal duct, the Eustachian tube, and the jugular veins.

The symptoms above enumerated are, unfortunately, not characteristic; they may be, and often are, simulated by other affections. Thus, the person may labor under enlargement of one of the turbinated bones, hypertrophy of the mucous membrane, malposition of the nasal septum, or malignant disease, either of the nose itself, or of the maxillary sinus; or, finally, there may be a foreign body in the nose, causing serious obstruction, and profuse, sanious, and fetid discharge. A remarkable case has been recorded by Cruveilhier, in which a fibroma of the sheath of the second branch of the fifth pair of nerves made its way into the nostril through the sphenopalatine foramen, and was mistaken for a polyp. Attempts at evulsion were followed by death from meningitis. To make sure of the diagnosis, the polyp must be seen or felt. Protrusion at either opening of the nose at once decides the matter; but, in the absence of this, a careful inspection is made with the speculum, in a strong light, with the head inclined backwards; a grooved director is used, if necessary, to move the tumor about, and determine its size, consistence, and point of attachment. If the tumor is covered with mucus, clearance is first effected by blowing the nose, or, this failing, by means of a pellet of cotton wrapped around the end of a probe. When the polyp lies far back, it may project into the fauces, and thus satisfactorily reveal its character; should it not yet have descended, the index finger is introduced into the mouth, and carefully carried around the velum of the palate.

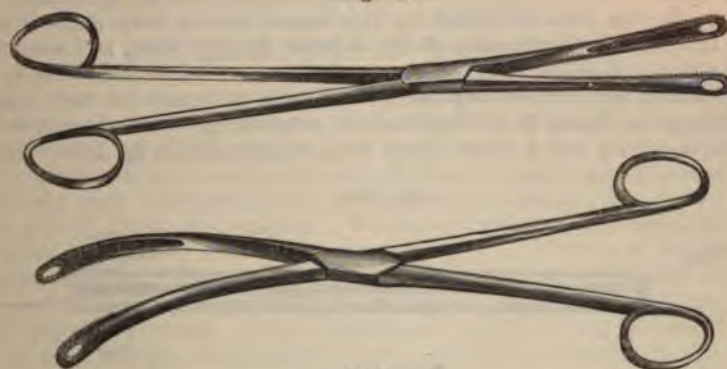
There are several circumstances which generally serve to distinguish a gelatinoid from a fibroid polyp. In the first place, they differ essentially in their complexion; the former being always white, like an oyster, a lump of mucus, or a mass of jelly, while the latter is of a deep red, purple, or modena color. Secondly, the gelatinoid polyp is generally smaller, and, consequently, its existence less marked in dry than in damp weather, which is not the case with the fibroid tumor, which is not affected by atmospheric vicissitudes of any kind. Thirdly, the discharge is always less profuse, less offensive, and less bloody in the gelatinoid than in the other form of the disease; and, finally, there is rarely any involvement of the general health in the former affection, while in the latter it seldom escapes, especially in the advanced stages. Moreover, the fibroid polyp usually grows much more rapidly than the

other, and has a much greater tendency to encroach injuriously and disfiguringly upon the surrounding structures.

Of the *causes* of nasal polyps nothing is known. The disease is often ascribed to the effects of external injury, the employment of snuff, the habit of picking the nose, and the irritation of decayed teeth; but it is very questionable whether it is ever induced in this way. Males suffer from it much oftener than females. Polyps may attain a large size in a few months; or, after having made some progress, remain stationary for an indefinite period. I have seen the gelatinoid tumor attain, in less than a year, the volume of a hen's egg.

Treatment.—There is no doubt that a gelatinoid polyp of the nose is occasionally amenable to local remedies; but the cures thus effected are uncommon, and cannot serve as rules of practice, even in ordinary cases. At one time a good deal of confidence was placed in the use of finely pulverized bloodroot, as a snuff, in the treatment of this affection; the insufflation of tannic acid has also been recommended; and, in 1859, Dr. J. H. Reeder, of Illinois, published the particulars of

Fig. 276.



Polyp-forceps.

two cases in which prompt cures were obtained by strong injections of the tincture of chloride of iron, conjoined with the application of a piece of sponge moistened with a solution of this article to the cavity of the nose. The best plan, however, generally is not to waste any time in this way, but to proceed at once to the removal of the tumor. Fortunately, this is usually easily effected by torsion with the forceps. Very suitable instruments for this purpose are represented in the adjoining sketches, fig. 276. They are very light and slender, being seven inches and a half in length, and provided with large rings. The blades, which are nearly three inches long, are fenestrated, and grooved internally, with well serrated margins. The great fault of the common polyp-forceps is that they are too short and clumsy. When the tumor is situated in the upper and back part of the nose, a curved instrument may sometimes be advantageously employed. The mode of applying the forceps is represented in fig. 277.

The patient being seated upon a chair, in a strong light, with the head supported upon the breast of an assistant, the operator introduces the forceps as high as the origin of the tumor, which is then seized by expanding the blades over its pedicle, and twisted off by turning the instrument several times very gently upon its axis. No pulling or traction is permissible, lest injury should be inflicted upon the mucous membrane, or the turbi-

Fig. 277.



Mode of Extracting a Nasal Polyp.

nated bone be torn away. If the first attempt is unsuccessful, or if a part of the polyp is broken off, the instrument is reinserted, again and again, until the object is accomplished, not a particle of the growth being left behind, it being desirable, if possible, to effect complete clearance at one sitting. When there are several tumors, they should all be dealt with in a similar manner. The blood which flows during the operation has a tendency to conceal the polyp, but it is easily dislodged by blowing the nose, the sound nostril being compressed, to render the effort more effective. If riddance is impracticable in this wise, a stream of cold water, or of vinegar and water, is thrown up with a large syringe. It is rarely necessary to suspend the operation on account of hemorrhage; the bleeding is usually slight, and nearly always ceases spontaneously in a few minutes. When it threatens to be copious and persistent, plugging of the nose may be proper.

When the tumor is situated far back in the nose, or hangs down into the fauces, it may occasionally be broken off with the index-finger, introduced into the mouth, and carried round the palate. In this way I promptly succeeded in removing, not long ago, a large gelatinoid polyp from a youth of seventeen; but I have no idea that the procedure would answer in the fibrous polyp, or even in a gelatinoid one with a broad base. In the case adverted to, the tumor had a very narrow footstalk, attached to the posterior extremity of the inferior spongy bone, and was, therefore, easily torn away. Nothing can be accomplished here with the forceps, however ingeniously curved and dexterously used, as there is no space for their application. When, therefore, the means just described are unavailing, removal must be effected with the double canula and a stout silver wire, represented in fig. 278. The instru-

Fig. 278.



Double Canula.

ment, which is four inches and a half in length, is conveyed along the floor of the nostril as far as the fauces, when the loop of the wire is properly expanded, and passed around the neck of the tumor, as near as possible to its origin. The ends of wire are then firmly but cautiously pulled, and secured to the shoulders of the canula. The annexed cut, fig. 279, exhibits the mode of applying the instrument.

Fig. 279.



Mode of Ligating a Nasal Polyp.

The strangulation is seldom completed under three or four days, during which it is necessary to tighten the wire occasionally. When the polyp is nearly ready to drop off, the finger is introduced into the fauces, and the canula rotated on its axis, to promote the separation, lest, taking place during sleep, the tumor pass into the wind-

pipe or œsophagus. In the gelatinoid form of the disease, the safest and most expeditious plan is to twist off the polyp the moment it is fairly embraced with the wire. I have occasionally succeeded in removing a fibrous polyp, when situated far back on the floor of the nose, or at the posterior naris, with an instrument shaped like a common chisel, about two lines in width, and beveled off to a moderately sharp edge on one side of its extremity. The growth is easily scraped away from its connections, especially if counter-pressure be applied to it with the index finger in the fauces. The operation, however, is liable to be attended with a good deal of bleeding, rendering it occasionally necessary to plug the nose.

Fibrous polyps may be removed more rapidly than by strangulation, and, probably, with equal safety as regards the occurrence of hemorrhage, either by the wire *écraseur* or the galvanic noose of Middeldorpf. The latter measure, however, is rarely applicable in private practice.

When the fibrous polyp is of extraordinary bulk, and quite inaccessible by the means now pointed out, its removal can be effected only by the knife, or the knife and saw. When the disease is carcinomatous, no operation should be attempted, not even with a view to temporary alleviation; much blood will be likely to be lost, the manipulations will be tedious and painful, and the patient may die on the table. Under opposite circumstances, the operation is performed at all hazards, and with a prospect of a favorable issue. An incision, in the form of an inverted **J**, is made along the junction of the nasal and maxillary bones, commencing immediately below the lachrymal sac, and terminating a little below the level of the nostril, the flaps being dissected up, and held asunder.

No particular treatment is required after the more common operations of this kind; there is usually very little inflammation or discharge, and in a few days the patient is able to go out about his business. To prevent relapse, it is customary to inject the nose once a day with some astringent wash, as a solution of nitrate of silver, zinc, copper, or alum. The practice may, however, in general, be advantageously dispensed with; it is only when there is evidence of persistent morbid action that it is likely to prove beneficial. In the gelatinoid variety of the affection, where the tendency to regeneration is sometimes most remarkable, and also in the gregarious form of this disease, I have occasionally broken off as much as one-half and even two-thirds of the implicated spongy bone, believing that this procedure was greatly preferable to the frequent repetition of the ordinary operation.

For the removal of *naso-pharyngeal* polyps two distinct operations may be practised; one of which, originally proposed by Nélaton, consists in the division of the soft and hard palate, and the other, devised by Langenbeck, in the temporal depression of the upper jaw. Excision of the entire maxilla, first executed by Syme in 1832, and at one time recognized as a justifiable procedure, is no longer deemed advisable. The method of Nélaton is more especially applicable when the tumor is situated partly in the nose and partly in the pharynx, or when it springs from the middle of the base of the skull, the superior portion of the spine, or the internal surface of the pterygoid process, at the same time sending a prolongation into the pharynx. It is executed by dividing, first, the soft palate in its whole length, and then, by means of the saw and pliers, so much of the hard palate as may be necessary to afford complete access to the parts, the mucous membrane and periosteum having previously been raised from the bone. When the tumor is not very bulky, the operation may be limited to the soft palate, as advocated by Mandé, of Avignon, in 1747, and modified by Maisonneuve, in 1859, by leaving the uvula intact. Through this opening, denominated the "palatine button hole," the base of the growth is encircled by a loop of wire and removed by crushing.

Depression of the jaw, as originally practised by Langenbeck, in 1859, is required when the polyp springs from the petrous portion of the temporal bone, the petro-occipital suture, or the borders of the foramina lacera, thus rendering it inaccessible by the mouth. When the tumor is of unusual bulk, or when it has very firm and extensive attachments, it may be necessary to invade both bones, as in the remarkable case of Dr. Cheever, of Boston. In the operation, as performed by the Berlin Professor, a slightly crescentic incision with the convexity downwards is made from the ala of the nose along the lower border of the malar bone as far as the middle of the zygoma. A second incision, beginning at the centre of the root of the nose, is carried along the inferior margin of the orbit, across the frontal process of the malar bone, and joins the other at an obtuse angle. Leaving the integument intact, the

periosteum is now divided along the tracks left by the knife, and the masseter muscle separated from its connection with the malar bone. With a narrow saw the jaw is cut through horizontally from behind forwards, the point of the instrument being guided by the finger introduced through the mouth into the posterior naris. The saw is then moved in the line of the upper incision as far as the lachrymal bone. The flap of jaw, if so it may be termed, made by this procedure, is thus left merely adherent to the nasal bone, and to the ascending process of the maxillary bone, covered by its soft parts. The hard palate and the alveolar process also retain their integrity. The loosened jaw is now slowly pried upwards by an elevator inserted beneath the malar bone, and moved as on a hinge upon the sutures between it and the nasal and frontal bones. The tumor, thus rendered accessible, is then removed, when the jaw is restored to its natural position, the edges of the wound being united by suture.

When Langenbeck's last report of this operation was made in 1869, he had performed it altogether thirteen times, with ten complete cures and three deaths, the latter being cases in which the morbid growth had perforated the base of the skull, and in which removal was followed by meningitis. Osteoplastic resection, as this operation is now generally called, has also been practised by other surgeons, as Esmarch, Wagner, Weber, Billroth, Simon, and Cheever.

Dr. Cheever, who was the first to repeat Langenbeck's operation in this country, has reported the particulars of two cases, in one of which he was compelled, on account of the great size and median situation of the tumor, to divide both jaws in order to obtain the requisite degree of access. The primary incision extended along each side of the nose in the direction of the natural wrinkle from near the inner canthus of the eye around the ala through the middle of the lip. The flaps being freely reflected as far upwards as the malar prominences, and the body of the bone divided with a narrow saw from the tuberosity forwards on each side to the middle meatus of the nose, the nasal septum and vomer were cut with strong scissors. The two jaws, hinging merely on the pterygoid processes, were now depressed, thus exposing the tumor, the attachments of which to the sphenoid and ethmoid bones were severed with scissors and chisels. The jaws were then restored to their normal position and retained firmly by silver wire passed on each side through the malar bones. The operation, which reflects great credit upon Dr. Cheever, unfortunately proved fatal at the end of the fifth day from exhaustion, although the man had not lost much blood.

Ollier, in a case of polyp weighing six ounces, effected removal through the upper meatus by turning down the nose over the upper lip by a \cap -shaped incision, commencing over the bridge of the nose, and sawing through the organ obliquely from above downwards. The root of the flap in this procedure is at the junction of the ala and septum of the nose with the upper lip. When the tumor is very large, or situated unusually far back, Ollier suggests a second incision carried backwards from the meatus to meet the previous one, in order that, by lifting out a wedge from the jaw, more easy access may be obtained to the morbid growth.

None of these operations are followed by any serious mutilation, and as the flaps have an abundant arterial supply there is no danger, if proper attention be paid during the after-treatment, of gangrene. The great risk after all of them is from erysipelas and septicemia. The bleeding is generally easily controlled. Free use should be made during the progress of the cure of chloralum and other means of cleanliness. A remarkable fact in connection with these procedures is that the palatine operations are more unsatisfactory than those in which ablation of the jaw is practised. Thus, of 25 cases of the former collected by Verneuil, 7 died, while of 11 examples of total resection only 1 proved fatal.

In a case of naso-pharyngeal polyp with strong attachments to the borders of the posterior naris and the base of the skull in a young man under my charge, in 1869, I succeeded, after a good deal of effort, in wrenching off the tumor by means of a strong volsella passed through the inferior meatus, the inferior turbinated bone having previously been pushed aside to facilitate the necessary manipulations. The growth was of a very firm, fibroid character, fully the size of a pullet's egg. Very little hemorrhage attended the operation, but there was so much oozing of blood the next day as to require the insertion of a tampon, wet with Monsel's solution, behind the palate.

Evulsion, however, is not free from danger. In a case recently recorded by Mr.

Cooper Foster, it was attended with fracture of the cribriform plate of the frontal bone and followed by death, on the twelfth day, from general arachnitis and limited sloughing of the brain.

Whatever process be adopted, the surgeon cannot fail to perceive the necessity of thorough work. With this view, after the main tumor has been removed, its base should be completely scraped away, along, if possible, with the mucous membrane and periosteum to which it was attached. To do less, would only entail a speedy recurrence of the disease.

13. *Exostosis*.—Exostosis of the nasal cavity is a very uncommon occurrence. It probably, in most cases, originates in the antrum of Highmore, from which it gradually extends into the nasal cavity by causing absorption of the surrounding osseous structures, as the wall of the antrum, the vomer, and the spongy bone. However this may be, the growth may eventually acquire a very large bulk, completely obstructing the nasal cavity, and occasioning great deformity of the face. The principal symptoms are muco-purulent discharge, pain, and impediment in respiration. The diagnosis is established with the finger and probe. The structure of the tumor is generally of ivory-like consistence, interspersed with small cavities occupied with gelatinoid, fibrous, or cartilaginous matter. Removal is effected with the knife, saw, pliers, and chisel, either through the nose; or, if the mass is very bulky, through the face. Spontaneous detachment sometimes occurs, as in the remarkable cases reported by Legouest and Dr. Duka, of Bengal, in both of which, however, notwithstanding this circumstance, dislodgement could not be effected until after the partial removal of the superior maxillary bone, so completely were the tumors impacted in the nasal cavity. In cases of this description, it is very probable, as Dr. Olivier, of Paris, suggests, that the tumor is developed from the membranes rather than from the bones of the nasal cavity.

14. *Enchondroma*.—The cartilaginous tumor of the nasal fossa is extremely uncommon: in the few instances in which it has hitherto been observed, it occurred in connection with the septum, or the septum and floor of the nose, in young subjects. It has been observed to be combined with sarcoma, as in the case recorded by Mr. Stanley; and in such an event the growth differs from true enchondroma in its rapid growth and its disposition to penetrate the skull through the ethmoid bone. As the cartilaginous tumor rarely attains a large size, it may be removed through the nostril with the gouge and chisel.

15. *Malignant Tumors*.—The nose is occasionally the seat of sarcoma, scirrhus, and soft, medullary, or glandular epithelioma; sometimes by extension from the maxillary sinus, but more generally by direct development from the bones, periosteum, or glands of the mucous membrane; chiefly in children and young persons; marked by the usual local symptoms, and invariably tending to destruction. The tumor, which may spring from almost any part of the nasal cavity, is liable to be confounded with polyp; but from this it may commonly be readily distinguished by its broad attachment, by the remarkable rapidity of its growth, by its disposition to encroach upon the surrounding structures, and, in the case of carcinoma, by the great abundance and foulness of the accompanying discharge, and by the early appearance of constitutional cachexia. The tumor is very friable, and often bleeds profusely from the slightest injury. The horrible disfigurement produced by this disease is well represented in fig. 280.

The treatment is purely palliative, operative interference being entirely out of the question. By attention to cleanliness, a nourishing diet, and the use of opiates, the patient is rendered comparatively comfortable, and enabled to eke out his miserable existence.

Fig. 280.



Carcinoma of the Nose.

CHAPTER IX.

DISEASES AND INJURIES OF THE AIR-PASSAGES.

THE principal surgical affections of the air-passages are, inflammation, œdema, croupous deposits, ulceration, morbid growths, epithelioma, spasm, stricture, and foreign bodies. Before I proceed to describe these lesions, it will be necessary to offer some remarks upon the proper mode of inspecting the air-passages with a view to their more ready detection.

I.—EXAMINATION AND MEDICATION OF THE LARYNX.

The investigation and treatment of the maladies of the larynx and trachea were, until recently, much embarrassed for the want of proper mechanical appliances by which the interior of these structures could be brought into view; but the difficulty has, in great measure, been overcome by the introduction of the laryngoscope by Dr. Czermak, of Vienna, who commenced his researches in 1857, and to whom is undoubtedly due the credit of being the first to employ such an instrument upon scientific principles, although a similar idea had previously occurred to Babington, Beaumès, Liston, Garcia, and others.

Fig. 281.



Laryngeal Mirror.

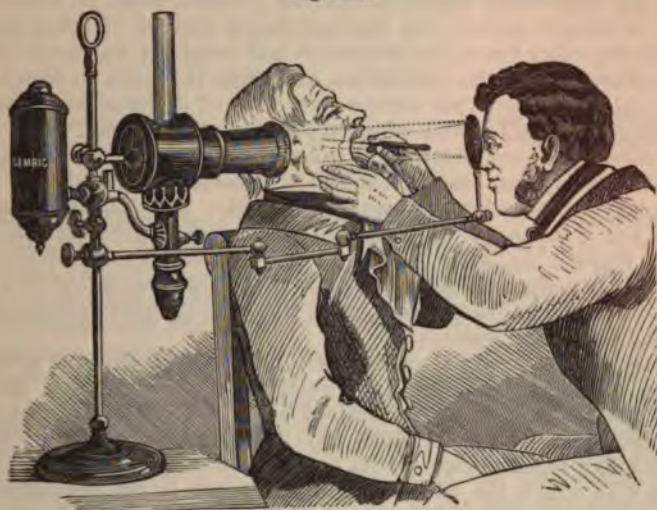
The laryngoscope consists of a highly polished steel mirror, fig. 281, of a square, oval, or circular shape, mounted on a flexible but firm rod secured in a movable handle, and, on an average, about two-thirds of an inch in diameter by one line in thickness. Previously to its introduction it should be heated to as high a temperature as may be consistent with the comfort of the patient, either by holding it over the flame of a spirit lamp, or by plunging it into hot water, to prevent the respired air from becoming condensed upon its polished surface, and so rendering it unfit for use.

To light up the larynx and pharynx, a slightly concave glass mirror, resembling the ophthalmoscope, about three inches in diameter, with a small central perforation, is used. This is fitted in a light metallic frame, which is secured to a mouth-piece, by which the reflector may be held between the teeth; or, instead of this, it may be attached to a frontlet, or band encircling the head, the central aperture corresponding with the eye of the observer. In Tobold's apparatus it is attached to the stem of the lamp. The light of an argand lamp, concentrated upon the reflecting mirror, constitutes the best source of illumination, but, when available, the direct rays of the sun may be employed.

In conducting the examination, the lamp is placed on a table a little behind and to the right of the patient, so that the flame may be on a level with the roof of the mouth. The patient rests his hands upon his own knees, slightly advances his body, and throws the head a little backwards, the mouth being well opened and the tongue depressed. The observer, seated directly opposite to him, uses his left hand to support his neck and chin, or to control his tongue, while with the right he holds the laryngoscope, at the same time looking through the perforation of the reflecting mirror. The light and the position of the observer and patient being thus properly regulated, as delineated in fig. 282, the former warms the instrument in the manner above indicated, and requests the latter to take alternately a deep inspiration and to sound the vowels *a*, *e*. By this procedure the velum and uvula will be raised, allowing the easy introduction of the instrument, to which a proper inclination should then be given, so that the rays of light from the reflecting mirror may illuminate it. The speculum, by throwing the rays upon the larynx, reflects the reversed image of the parts to the eye of the observer.

With a little perseverance, any one may soon learn to bring into view the base of the tongue, the epiglottis, the vocal cords, the ventricles of the larynx, the Eustachian tubes, the posterior nares, and even the bifurcation of the trachea. It is advisable, however, to begin the study upon the excised human larynx, or to make the

Fig. 282.



Mode of Conducting a Laryngoscopic Examination.

examination upon one's own person, in order that the observer may gain a sufficient amount of proficiency in the use of the instruments before applying them to a patient, as well as to accustom himself to the altered position of the parts, as, in the reflected image, they are seen upside down, but in their proper position in relation to the right or left side of the body. Great care must be taken in introducing the mirror to avoid unnecessary touching of the fauces and pharynx, lest the act of swallowing or vomiting be provoked; and in some subjects the parts will be found to be so irritable as to require some preliminary training, as in the operation for cleft palate, to render them tolerant of the presence of the speculum. When it is desired to medicate the larynx, the self-retaining tongue depressor of Dr. Henry Church, of New York, or the laryngoscopic mouth-piece of Dr. Elsberg, will be found very convenient, as it leaves one hand of the operator free to apply the necessary remedy.

The instrument of Dr. Church, besides serving the purpose of a tongue depressor, is an excellent laryngoscope, readily bringing into view, when properly applied, the cavity of the larynx, the vocal cords, and the rima of the glottis. It consists, as will be seen by reference to fig. 283, of two pieces, connected by an arm provided with a hinge-joint, the one being a kind of reflecting spatula, while the other is a metallic plate, shaped like the lower jaw, which rests in it in a sort of gutter. The spatula being introduced into the mouth, its angle of flexion is easily regulated by the screw: in this manner the tongue may not only be readily depressed, but forced forwards and kept completely quiet, at the same time that the mouth may be opened and shut without the slightest inconvenience to the patient or any displacement of the instrument.

Fig. 283.



Dr. Church's Laryngoscope and Tongue Depressor.

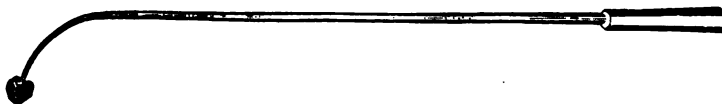
The treatment of affections of the air-passages by *cauterization* has attracted great attention within the last twenty-five years, both in this country and in Europe, chiefly through the exertions and influence of the late Dr. Horace Green. Unfortunate in the manner of its introduction, it has met with much opposition and even obloquy, and there are many able practitioners who altogether deny its practicability, alleging that the instrument employed for the purpose, when it descends beyond a certain point, is always thrust into the œsophagus instead of being passed into the air-tubes. On the other hand, the treatment has received the approval of some of the highest authorities in the profession, and there is reason to believe that it has already rendered most important service in a class of diseases which, until its adoption, were generally found to be of a very hopeless character. The operation of mopping the windpipe is unquestionably not an easy one, but that it may be executed by any one of ordinary tact, and possessed of a correct knowledge of the anatomy of the parts, my observation abundantly attests. That the instrument is often passed down the œsophagus by awkward and ignorant practitioners is, I think, equally true. Experience is in this, as in every other operation requiring delicacy and skill, of vast benefit, and there is no doubt that he who enjoys it in the greatest degree is, all other things being equal, most likely to succeed in cauterizing the air-passages with facility and success.

Cauterization of the larynx is particularly indicated in chronic affections of this tube, whether simple, syphilitic, or tubercular, or dependent upon the presence of warty excrescences. It is also very efficacious in acute inflammation, especially in that variety denominated membranous croup. Aphonia, caused by disease of the larynx, is likewise a suitable case for its employment.

The article with which the cauterization is effected is the crystallized nitrate of silver, in the form of solution, in the proportion of twenty to forty grains to the ounce of water. When ulceration is present, or when the medicine has ceased to produce the desired effect, the strength of the solution may be considerably increased; but for ordinary purposes this is unnecessary.

Ingenious instruments for mopping the air-passages have been devised by Semeleder, Elsberg, Gibb, and others. Ordinarily, a probang, like that sketched in fig. 284,

Fig. 284.



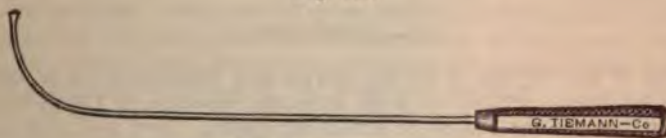
Sponge-probang for the Larynx.

answers sufficiently well. It consists of a thick whalebone rod furnished with a stout handle, and bent at an angle of nearly 45° , the curved extremity being surmounted by a camel-hair brush or small, round piece of sponge, of great softness and delicacy, and securely attached by means of a strong thread. The whole instrument is about ten inches in length. The sponge or brush being slightly moistened with the caustic solution, the patient, seated upon a chair, is requested to open his mouth as widely as possible, and to take a full inspiration, followed by a gentle expiration, thus placing the parts in the best condition for the easy introduction of the instrument, and the prevention of spasmodic cough. While this is being done, the surgeon depresses the tongue, and carries the probang over the top of the epiglottis, and thence suddenly on, over the lower surface of that cover, downwards and forwards through the mouth of the larynx into the interior of that tube. A momentary contact is all that is necessary. The operation is generally followed by some cough, but this soon passes off, leaving the part and system comparatively comfortable. When the spasm is unusually violent, threatening suffocation, I have found the best remedy to be the inhalation of a little chloroform, which usually affords almost instantaneous relief. The operation in chronic diseases should not be repeated oftener than every third or fourth day; in acute, on the contrary, it may be required every eight, ten, or twelve hours.

For applying solid nitrate of silver to the larynx and epiglottis, the most simple and efficient instrument that I know of is that of Dr. Lente, sketched in fig. 285. In the use of this substance great care must be exercised that it does not break off and fall into the windpipe.

Injections of nitrate of silver may be practised when the disease is situated in the trachea and bronchial tubes beyond the reach of the probang, the operation being performed with a small syringe, fitted to a narrow gum-elastic catheter, a little upwards of one foot in length, inserted into the mouth of the larynx, and thence passed rapidly

Fig. 285.

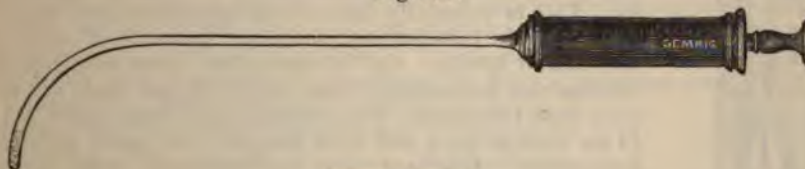


Lente's Porte-caustique.

on into the windpipe, leaving only about two inches and a half of the tube projecting beyond the front teeth. The fluid must be thrown in as quickly as possible, lest the procedure provoke violent coughing, and thus prove abortive. The strength of the solution should vary from ten to twenty grains of the salt to the ounce of water, to be gradually increased with the tolerance of the parts, the quantity injected at any time not exceeding a drachm and a half, one-third, or less, of this being quite sufficient at the beginning of the treatment. The operation, which is often followed by severe spasm, and which requires unusual dexterity for its successful execution, may be repeated every third, fourth, or fifth day, according to the exigencies of the case.

When the object is merely to medicate the larynx, or the larynx and upper part of the trachea, the operation may be performed with the instrument delineated in fig. 286. It consists of a silver tube, perforated at the end, and attached to a small

Fig. 286.



Laryngeal Syringe.

rubber syringe. It is charged in the usual manner, and then passed between the lips of the glottis, the fluid being thrown into the air-passages in a number of fine jets.

Medicated *sprays* are now much used in the treatment of diseases, both acute and chronic, of the air-passages, and there is no doubt that they are often highly beneficial. The articles generally selected are nitrate of silver, alum, tannic acid, and tincture of chloride of iron, in solution, very weak at first, and gradually increased in strength, according to the tolerance of the parts.

When the fauces and air-passages are very irritable, or the patient is uncommonly timid or unmanageable, it will be well to institute a kind of preliminary treatment, consisting in the frequent application of the finger, and of various instruments, to the tongue and throat, so as to educate the parts for the approaching ordeal, as in the operation of staphylorraphy. If the fauces are inflamed, they should at the same time be occasionally touched with nitrate of silver.

II.—CONGENITAL DEFECTS.

Partial occlusion of the rima of the glottis sometimes exists as a congenital affection, as in the interesting cases observed by Dr. Elsberg and Dr. Zurhille. In the former of these cases, that of a girl seventeen years of age, the vocal cords were covered by a thick, tough, fibro-elastic membrane, so arranged as to leave only a small opening at the posterior part of the larynx for the entrance of air. When the cords were forcibly stretched, the opening was irregularly circular, and hardly a quarter of an inch in diameter. The ventricles of Morgagni were unusually wide and deep. The voice was feeble, hoarse, husky, and squeaky. Dr. Elsberg cut out a portion of the abnormal membrane, and succeeded in effecting a marked improve-

ment in the condition of the vocal and respiratory functions. In the case of Dr. Zurhale, a kind of double membrane existed, one of which united the anterior two-thirds of the vocal cords, while the other was situated farther down in the tube, under cover of the upper. The voice, it is said, became natural after the division of the abnormal structures.

III.—LARYNGITIS.

Inflammation of the larynx, or of the larynx and trachea, is an exceedingly common affection, the result usually of cold, external violence, or the inhalation of the steam of hot water, or the fumes of irritating gases. Not unfrequently it arises from the effects of the syphilitic poison. As generally met with, the disease is most common in young children, in whom it ordinarily assumes the form of croup, which occasionally manifests an endemic character, and is extremely liable to be followed by a deposit of plastic matter, accurately moulding itself to the interior of these

Fig. 287.



False Membrane of Croup.

canals, and closely adhering to their surface. In the more aggravated cases, the deposit extends, on the one hand, up into the throat, and on the other, down into the lungs, thus causing great, if not fatal, mechanical obstruction to respiration. In 120 cases examined by Housenot, it was confined to the larynx and trachea in 78, while in 42, or one-third, it passed into the larger bronchial tubes. Fig. 287 exhibits this deposit as it occurred in one of my specimens removed from a lad who died of croup.

In that form of plastic deposit known as membranous croup, tracheotomy is occasionally employed; generally, however, at so late a period of the disease as to be of no permanent benefit. This is especially true of the operations that have been performed in this country, the great majority of which have terminated fatally. Of 783 cases that have occurred at the Hôpital des Enfants at Paris, 191, or 25 per cent., are said to have been successful. The subjects in all these cases had been ill for several days, and were affected with great difficulty of inspiration. Guérant, who has furnished these statistics, states that he has performed this operation 156 times in private, and saved 28 children, or 1 in $5\frac{1}{2}$. Of 141 cases analyzed by Martini, 66 were cured, and 75 died. As an offset against these results, it may be added that of 351 cases of tracheotomy, performed on account of this disease, by twenty-one French surgeons, including a number of the most distinguished operators of Paris, 312 terminated fatally, affording thus a ratio of 8 deaths to 1 recovery. One of these surgeons operated forty times, and lost every one of his patients. Dr. A. Jacobi, of New York, in 1868, published the results of 213 cases of tracheotomy, performed by himself, Voss, Krackowizer, and Von Roth, of which 50, or $23\frac{1}{2}$ per cent., recovered.

In diphtheria, as in croup, tracheotomy is seldom a successful operation, and still it is, in my judgment, in many cases, a highly proper one. Even when it cannot save life, it should often be performed to prevent impending asphyxia, and thus afford the patient the benefit of a more easy mode of death. The operation is usually more fatal in very young children than in adolescents and grown-up persons, not, perhaps, on account of any greater amount of blood-poisoning, but simply because it is generally so difficult to effect proper medication. The most favorable subjects for tracheotomy are those in whom the plastic deposit is mainly confined to the throat and larynx, without any serious disease of the trachea, lungs, and bronchial tubes. Whenever these structures are at all extensively implicated, no treatment, whether medical or surgical, will be likely to be of any permanent avail.

When tracheotomy is performed for either of these affections, a double canula must be worn until the urgent symptoms have passed off, when it may be removed, and the wound allowed to heal. The instrument should be frequently cleaned, and care taken that the air of the patient's apartment is not only kept moist but at a temperature of eighty-two to eighty-five degrees. Sometimes large masses of plastic matter are discharged through the wound or by the mouth. In the latter event,

asphyxia may be caused by the lodgment of some of the substances in the glottis, or by its imperfect expulsion from the larynx.

The most common cause of death, after tracheotomy for croup, diphtheria, and ulceration, is suffocation, or exhaustion from previous suffering, from congestion of the lungs, and inadequate supply of air. Occasionally the patient perishes from œdema of the glottis, ulceration of the mucous membrane of the larynx, erysipelas, pyemia, or hemorrhage. In a case of croup under the charge of Dr. Wilks, of London, the child died five days after tracheotomy from ulceration of the innominate artery. Copious hemorrhage sometimes occurs at the edges of the wound, from the inflamed and congested condition of the mucous membrane. The proper remedy, in such an event, is the ligature, if the blood proceeds from distinct vessels; the actual canter, if it oozes from numerous points. A number of examples of fatal hemorrhage from this cause have been reported. The presence of the cannula, after tracheotomy, occasionally excites ulceration in the wound, and even suppuration in the structures around the windpipe.

Syphilitic laryngitis generally belongs to the tertiary group of syphilitic phenomena, a form of the affection which, as it has been described in another part of the work, need not be reconsidered here. The proper treatment is by the iodides in union with mercury, tonics, and stimulants. When great respiratory difficulty supervenes, the only hope for the patient is tracheotomy.

Laryngitis is occasionally of a tubercular nature, and then nearly always passes into ulceration. Its coexistence with phthisis renders it nearly uniformly fatal.

Gangrene of the larynx is exceedingly uncommon, and must almost necessarily terminate fatally under any mode of treatment, however skilfully conducted.

IV.—CEDEMA.

The larynx is liable to œdema. The parts which are most commonly affected are the glottis, the lips of the organ, and the epiglottis, the edges and under surface of which are usually thickened and pulpy. The disease, considered by many as of an erysipelatous nature, consists in an effusion of serum, or serum and lymph, in the submucous cellular tissue, leading to mechanical obstruction of the tube, and serious impediment in the respiratory functions. The swelling is devoid of vascularity, pits on pressure, and is generally most prominent around the margins of the larynx, which are often elevated into white, glossy, pendulous bags, not unlike those of the epidermis after the application of a blister. Small purulent deposits are sometimes seen in it, while its surface is occasionally incrustated with patches of lymph. The swelling is of a pale straw color, reddish, mottled, or greenish, and disappears almost completely when cut or punctured: The base of the tongue, pharynx, tonsils, uvula, and palate ordinarily participate in the morbid action, as is evinced by their inflamed condition. The mucous membrane of the larynx is heightened in color, and the lymphatic glands in the immediate vicinity of the tube are often enlarged, infiltrated, and softened. The adjoining cut, fig. 288, from a specimen in my collection, affords a good view of this disease.

Edema of the larynx is usually insidious in its origin, and rapid in its progress, often terminating fatally in a few days. It is more common in men than in women, and is rarely observed before the age of puberty. In children, it is sometimes induced by the inhalation of steam, or by drinking hot water from the spout of a tea-kettle. It often comes on suddenly, during the progress of different complaints, as scarlatina, measles, smallpox, tonsillitis, erysipelas, and typhoid fever.

The disease is marked by embarrassment of breathing, fits of coughing, change of voice, and threatened suffocation. Most commonly, the first indication is soreness of the throat, with a sense of constriction in the upper part of the larynx, as if there were a foreign body impacted in it. The voice is hoarse, sharp, hissing, or

Fig. 288.



Edema of the Larynx.

croupish; the cough is dry, sonorous, and convulsive; deglutition is painful; and the act of inspiration is performed with great difficulty and distress, while expiration is easy and unembarrassed. The obstruction to the breathing seems to depend, not so much upon the diminished capacity of the larynx, as upon the manner in which the tumid and infiltrated lips of the organ are drawn in by the air, as it rushes from the mouth into the lungs. The dyspnoea steadily increases; every respiratory muscle is called into play; the head is retroverted; the shoulders are elevated; the countenance is anxious and livid, from the imperfect aeration of the blood; and the poor patient, harassed with frequent paroxysms of suffocation, at length dies exhausted. High fever is always present in the later stages of the malady.

The distinctive signs of œdema of the glottis are, the difficulty of drawing the air into the lungs; the almost total absence of pain in the larynx; a feeling of fullness in the upper part of the pharynx, conveying the idea of the existence of an extraneous substance; soreness in the throat, and impediment in deglutition, often so great as to render it almost impossible to swallow either fluids or solids. In many cases, especially in females, in whom the distance between the lips and the affected parts is, in general, considerably less than in men, the end of the index finger may easily be brought in contact with the elevated epiglottis and the swollen lips of the larynx. In young, restive subjects, it may be necessary, in conducting the exploration, to depress the tongue with a spoon, and to separate the jaws with a piece of wood.

Too much attention cannot be bestowed upon the diagnosis of this disease, the nature of which is, unfortunately, too often overlooked. There are few practitioners who cannot recall to mind cases of this kind, and who have not had reason to regret their want of early discrimination, while life was still within the reach of remedies. An error of this description is the more to be lamented, because it is always fatal to the poor sufferer, who is sure to be suffocated by the mechanical obstruction which the swollen parts offer to the ingress of the air. The period at which death occurs from this cause varies from forty-eight hours to three, four, or five days.

The *treatment* of œdema of the larynx consists of purgatives and emetics, with leeches to the throat, followed by fomentations, and by blisters to the nape of the neck. General bleeding can only be required when the patient is young and plethoric. When the symptoms are urgent, the affected parts must be freely scarified, to afford vent to the effused fluids,

the cause of the whole respiratory difficulty. For this purpose, the long probe-pointed bistoury of Dr. Buck, fig. 289, with a short double-edged blade, bent at an angle of 45° , is carried into the larynx, and moved about in such a manner as to



Fig. 289.

Knife for Œdema of the Larynx.

divide the tumid and infiltrated structures at different points of their extent. The operation, which should be performed while the patient's head is thrown back, and firmly held by an assistant, the tongue being carefully depressed, and the jaws widely separated, is followed by hardly any bleeding, and is to be repeated at longer or shorter intervals, according to the amount of relief afforded.

The above treatment may often be advantageously aided by nitrate of silver, a solution of which, in the proportion of twenty grains to the ounce of water, should be applied freely, not only to the larynx, but also to the surrounding parts, which, as before stated, are generally seriously involved in the inflammation. If these means fail, and the obstruction to the respiration steadily advances, the only resource is tracheotomy, an operation which has often succeeded in such cases, under circumstances apparently the most desperate. In an instance under my care in 1855, although great relief followed the operation, the patient, a female, fifty years of age, died on the third day, from inflammation of the lungs. The ingress of air is promoted by a silver tube, or by means of hooks, as after tracheotomy for the removal of foreign bodies.

Of 168 cases of this disease analyzed by Sestier, 127 died. In 132, the ordinary treatment was adopted, with a loss of 104. Of 36 cases subjected to bronchotomy, 13 recovered, and 23 perished. Scarification has afforded by far the most cures.

V.—ERYSIPELAS.

The larynx is occasionally attacked by erysipelas, although very rarely as a primary disease; in general, it is merely an extension of the affection from the face, tongue, and throat. In 1844, '45, and '46, when erysipelas prevailed extensively as an epidemic in this country, many cases came under my observation in which it invaded the air-passages. In that form of the affection known under the name of "black-tongue," the morbid action usually began in the throat and fauces, or simultaneously in those parts and upon the scalp and face, as a red, glossy swelling, exceedingly painful, pitting under pressure, and attended with the most hideous deformity of the features. The inflammation rapidly extended to the larynx, the lymphatic glands, and the structures generally of the neck, and even the upper portion of the chest. The tongue was dry, excessively enlarged, of a dark livid hue, and incapable of protrusion; the uvula, tonsils, and arches of the palate were deeply discolored, rigid, and œdematous; the submucous cellular tissue of the larynx and trachea was extensively infiltrated with serum, or serum and lymph; the lungs were inflamed; the bronchial lymphatic glands were softened; and the thoracic cavities often contained a considerable quantity of serum and pus. If the patient survived any length of time, profuse suppuration, and sometimes even extensive sloughing, occurred; abscesses formed in the neck and other parts of the body; and ulcers, of different shapes and sizes, appeared in the throat. The parotid glands sometimes suffered very severely.

The general symptoms, in the more common forms of erysipelas of the larynx, are either of a low, typhoid character, or they soon assume that type; the pulse is weak, small, and frequent; the respiration is hurried and stridulous, inspiration being especially difficult; the stomach is oppressed by nausea, or nausea and vomiting; the bowels are constipated, the skin is hot and dry, the urine is high-colored and scanty, and there is excessive thirst, with great restlessness and anxiety. Delirium often sets in at an early period of the attack. The mucous membrane of the throat is of a red, scarlet, or crimson hue, and the glottis, as seen with the laryngoscope, is in an œdematous condition.

The danger in this disease is generally imminent, most of the cases terminating fatally within the first four or five days, the immediate cause of death being asphyxia or exhaustion. Those who survive have always a tedious convalescence.

The diagnosis rests mainly upon the history of the case, the peculiar character of the discoloration of the mucous membrane of the throat, the great swelling of the neck, the difficulty of respiration, and the coexistence of erysipelas upon the external surface. The discrimination will be very difficult, if not impossible, when the disease is confined mainly to the fauces and larynx.

The treatment must generally be of a tonic and supporting character, even in its very incipency. If the patient be young and robust, leeches may very properly be applied to the neck, over the region of the larynx, followed by a large blister; but the use of the lancet is usually wholly inadmissible. Emetics are often serviceable, especially when the throat and windpipe are clogged with mucus; and the bowels should be gently evacuated with a mild mercurial purgative. The most suitable tonics are quinine and iron with milk punch, and anodynes to allay pain and cough. If symptoms of asphyxia arise, relief should be attempted by scarification of the glottis; or, if the vital powers are not too far exhausted, tracheotomy may be performed. Abscesses of the neck, tongue, pharynx, and tonsils should be promptly opened, to abridge suffering and prevent suffocation.

VI.—ULCERATION.

Ulcers of the larynx, of a common, tubercular, syphilitic, or mercurial origin, are not unfrequently met with. Commencing usually in the muciparous follicles, or in little abscesses beneath the lining membrane, they are irregularly circular in their shape, superficial, from one to two lines in diameter, and surrounded by thin, grayish edges. The mucous membrane in their immediate vicinity is generally softened and abnormally red, but now and then it appears to be entirely sound. The ulcers, although they may occur in any situation, are most common in the vocal cords, the glottis, the base of the arytenoid cartilages, the ventricles of Morgagni, and the epiglottis, the latter of which is particularly liable to suffer in tertiary syphilis.

Fig. 290.



Ulceration of the Larynx.

distress, if not with a feeling of instant suffocation. In the more advanced stages of the malady, whatever may be its character or situation, the difficulty of swallowing is often so extreme that life is essentially abridged by starvation, the patient being sometimes unable for days together to take even liquids.

Ulceration of the larynx is always a dangerous disease. If the more common forms are occasionally recovered from, the more aggravated nearly always prove fatal.

Fig. 291.



Ulceration of the Epiglottis.

Ordinarily small and shallow, they sometimes occupy a large surface, or extend to a great depth, exhibiting a frightful appearance, and destroying, in their progress, muscles, ligaments, cartilages, and everything else that comes in their way.

The symptoms of ulceration of the larynx vary according to the nature, seat, and extent of the lesion. The syphilitic form, fig. 290, from Jones and Sieveking, is generally the most severe, but the tubercular is also not unfrequently attended with much pain and distress. When the vocal cords, the ventricles, or arytenoid cartilages are involved, there will be a sense of heat and pricking in the larynx, hacking cough, a husky, wheezing, or whistling state of the voice, and difficulty of breathing, along with purulent and bloody expectoration. As the disease progresses, the voice is reduced to a mere whisper, or becomes completely extinct, severe pain is experienced in the affected parts, hectic fever supervenes, and the patient finally dies from exhaustion of the vital powers, effusion into the lungs, or constitutional irritation. The suffering is greatly aggravated when the epiglottis is seriously implicated; for there is then not only dyspnoea, with cough and change of voice, but every attempt at deglutition is attended with great

distress. This is particularly true of the syphilitic and tubercular varieties, very few cases of which, especially in their more advanced stages, are ever cured under any treatment. The latter is, as a general rule, even more dangerous than the former. Serious involvement of the muscles, ligaments, and cartilages is always denotive of great danger, whatever may be the nature of the exciting cause of the lesion.

Ulceration of the epiglottis, usually the result of tertiary syphilis, may also be caused by the contact of irritating substances, as hot water, the alkalies, or corrosive sublimate, as in a case from which the annexed cut, fig. 291, was taken, and in which death followed in nine days from swallowing a large dose of this poison. The dissection revealed, besides ulceration of the epiglottis and surrounding parts, the existence of pneumonia, ulceration of the stomach, and inflammation of the entire intestinal track. The drawing is from Jones and Sieveking.

It must be obvious that the *treatment* of a disease, depending upon so many and such various causes, and the diagnosis of which is so obscure, cannot be conducted with much prospect of permanent relief. Indeed, experience has shown that temporary amelioration alone is usually to be looked for. When there is reason to believe that the lesion is owing to a syphilitic taint, mercury, iodide of potassium, nitro-muriatic acid, and kindred articles, must be employed. In ulceration, consequent upon tubercular deposits, little or nothing is to be expected from internal remedies, beyond the beneficial influence which they may exert upon the general health. In all cases, whatever may be the origin of the malady, permanent quietude of the affected organ is indispensable. Hence, the patient must refrain from all conversation, and even, as far as practicable, from deglutition. When there is much pain, soreness, or

tenderness in the parts, a few leeches may occasionally be applied to the front of the larynx, or the nape of the neck may be rendered raw with a blister. The best local remedy, however, is a solution of nitrate of silver, in the proportion of twenty to thirty grains of the salt to the ounce of water, with which the ulcerated surface should be gently but efficiently touched, in the manner above indicated, every third, fourth, or fifth day, according to the tolerance of the parts. If suffocation be threatened, tracheotomy may be performed, and a tube worn to facilitate respiration.

VII.—STRICTURE.

Stricture of the windpipe, fig. 292, may be induced by a deposit of fibrin in the mucous and submucous cellular tissues, or, as is more frequently the case, by the contraction consequent upon a wound, the healing of a large ulcer, or the death and exfoliation of a portion of one of its cartilages. Great diminution of the tube is occasionally produced by the pressure of an enlarged thyroid gland. The symptoms are those of impeded respiration, gradually increasing, and surely tending to the destruction of the patient. The diagnosis is established by the history of the case, and by a careful exploration of the tube with the probang. Relief may be attempted, although with hardly any prospect of success, by dilatation with the bougie, passed from the mouth, or from below upwards, through an opening in the trachea. The treatment is conducted on the same principle as in stricture of the urethra, œsophagus, and other mucous outlets. When the parts are very irritable, cauterization precedes the dilatation; and when the latter operation is impracticable, on account of the intractableness of the patient, control is effected by anaesthesia. In desperate cases the trachea is laid open, and a silver tube worn. By such a procedure, a patient may sometimes live in comparative comfort for many years.

Fig. 292.



Double Stricture of the Windpipe.

VIII.—TUMORS OR MORBID GROWTHS.

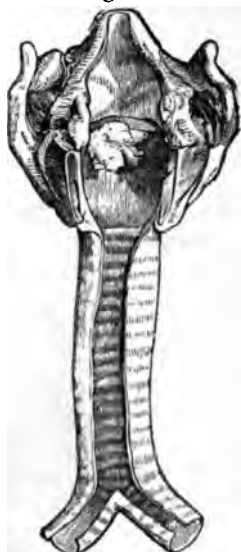
Morbid growths of the larynx, until recently described as polyps and warty excrescences, may be arranged, according to their anatomical characters, under the following heads: papillary, fibrous, myxomatous, sarcomatous, adenoid, cystic, lipomatous, and angiomatous, the supposed frequency of their occurrence being very much in the order here enumerated. The papillary tumor is more common than all the others together. Thus, of 100 cases observed by Dr. Morell Mackenzie, of London, 67 were of this description, and Dr. Cohen, of this city, met with 49 papillomas out of 66 morbid growths; results which tally very closely with the experience of other specialists. Compound growths, consisting of a combination of neoplastic elements, are not uncommon, the mixed structures being often so nearly balanced in quantity as to render it difficult, if not impossible, to determine which predominates. Of the carcinomatous growths of the larynx the epithelial is the most common. Encephaloid has been met with only in a few instances, and of colloid and melanosis I do not know that there are any recorded examples.

In regard to their form, tumors of the larynx exhibit great diversity; most commonly, however, they are globular, ovoidal, conical, or pyriform, and either perfectly smooth, or, as in the case of the papillary varieties, rough, granulated, or fissured upon the surface like a cauliflower, a mulberry, or a wart. Of a pale-rose, pink, red, or grayish color, they vary in consistence, according to their structure, from soft, gelatinous matter to dense fibrous tissue. Their volume ranges between that of a mustard seed and an English walnut. As it respects their mode of attachment, they are either sessile or pedunculated; more frequently the former. Their favorite seat is the interior of the larynx, at or near the vocal cords, which, in the cases observed by Mackenzie, suffered at the rate of nearly 75 per cent. Sometimes they are situated in the ventricles of Morgagni, at the root of the epiglottis, or at the border of the mouth of the larynx. Occasionally nearly the whole tube is involved. The

surface corresponding with the arytenoid cartilages enjoys a remarkable immunity from morbid growths of every description.

The papillary form of tumor is well illustrated by the annexed sketch, fig. 293; while fig. 294, from a drawing of a specimen in my collection, exhibits a fibrous

Fig. 293.



Papillary Growths of the Larynx in the Situation of the Vocal Cords.

Fig. 294.



Polypoid Fibroma of the Larynx.

growth, found in a man thirty-eight years of age, who finally died of tubercular phthisis, in a state of profound marasmus. The tumor was about the size of a filbert, and hung down into the lower part of the larynx by a rather narrow pedicle.

Morbid growths of the larynx are most common between the ages of forty and fifty; they are often met with in infancy and childhood; and cases occur in which they are either congenital, or in which they arise soon after birth. Men are much more liable to them than women. Of 287 cases, referred to by Mackenzie, 197 belonged to the male sex. Causit has collected 42 cases of laryngeal tumors occurring in early life, of which two-thirds were noticed in boys. What influence, if any, occupation exerts upon the production of these growths has not been determined. It is, however, generally believed that the constant use of the voice, as in speaking and singing, is a predisposing cause. Frequent attacks of cold, the inhalation of irritating vapors and particles of matter, chronic thickening of the mucous membrane of the larynx, and a strumous taint of the system probably act in a similar manner. Warty excrescences, or papillary tumors, are often directly traceable to the effects of the syphilitic poison.

The existence of these tumors is indicated by a sense of constriction in the larynx, alteration of the voice, croupy cough, occasional and gradually increasing dyspnoea, and more or less violent attacks of suffocation, especially when the morbid growth changes its position. There is seldom any pain. Dysphagia may be present when the tumor is unusually large, or when it is attached to the epiglottis. An alteration of the voice is one of the most constant symptoms. In old, chronic cases there is frequently either complete aphonia, or the patient is unable to speak above a mere whisper. The dyspnoea, seldom present to any extent in the earlier stages of the disease, gradually increases in intensity and frequency with the development of the tumor, and is generally of a paroxysmal character, worse at night than in the day-time, and liable to be aggravated by cold and change of posture. When cough is present, which, however, is seldom the case, it is usually dry and hacking, and often accompanied by a hoarse, croupy, or stridulous condition of the voice. Inspiration is generally more difficult than expiration; and, as the growth increases in bulk, the patient is often suddenly seized with a sense of suffocation, especially on lying down.

The *diagnosis* of laryngeal tumors can only be satisfactorily determined with the aid of the laryngoscope. Occasionally a portion of the tumor, or even the entire mass, is detached and ejected, thus, of course, dispelling all doubt respecting the nature of the disease. Among the more reliable rational symptoms are, the altered state of the voice and the violent attacks of dyspnoea, generally coming on suddenly and unexpectedly. When the growth is very pendulous, or attached by a long, narrow pedicle, it sometimes produces a flapping, valvular sound, as it moves about during respiration or change of posture. When the tumor is situated above the vocal cords, the voice will be likely to be noisy and stridulous; whereas, when the cords themselves are affected, aphonia will be present. Simple ocular inspection is sometimes sufficient to detect the morbid growth; only, however, when it is situated high up, or when it is connected with the epiglottis. Under similar circumstances a digital exploration may occasionally be advantageously made, as it may serve to determine the consistence and mode of attachment of the tumor.

To ascertain the size and position of the growth a laryngoscopic examination, repeated perhaps several times on different days, is essentially necessary, more especially if the parts are very irritable, or the patient does not properly coöperate with the surgeon. In trying to determine the nature of the tumor the chief points to be attended to are, its color, its consistence, and the appearance of its surface. Unfortunately, however, if we exclude the papillary and fibrous tumors, little light is to be obtained from such a mode of investigation, and even these do not always furnish very satisfactory data as it respects their precise characters. The papilloma is generally distinguished by its pink or reddish hue, its mamillary, fimbriated, or wart-like surface, its sessile base, its small size, the rapidity of its growth, and its great frequency in young subjects. The fibroma, which is next in the order of frequency after the papilloma, has a smooth and somewhat wavy surface, and is of a red color, round, oval, or pyriform in shape, and notably pedunculated, the latter forming one of its most characteristic features. Fatty, mucous, adenoid, vascular, and sarcomatous growths of the larynx do not furnish any diagnostic signs. The cystic tumor has a white, jelly-like appearance, not unlike a ranula, and is of a soft consistence, hemispherical in form, and encircled by a hyperemic condition of the adjacent surface.

The distinction between benign and malignant growths of the larynx is generally easy, the differentiation being based mainly upon the history of the case and the fact that the latter have generally a much broader attachment than the former. Moreover, if the disease has made considerable progress, the surface of the tumor will usually be found to be more or less ulcerated.

Gummy syphilitic tumors are most commonly met with on the posterior wall of the larynx, within the first three months after the occurrence of the primary sore, and they generally present themselves as slightly raised prominences, of a whitish or pale, yellowish color, strikingly contrasting with the red and injected mucous surface in their immediate vicinity. The coexistence of syphilitic disease in other parts of the body will assist the diagnosis.

Eversion of the mucous membrane of the ventricle of the larynx is mentioned by Mackenzie and others as an occasional source of error of diagnosis. The occurrence, however, is extremely rare, and a careful examination will generally readily dispel any doubt that may exist upon the subject.

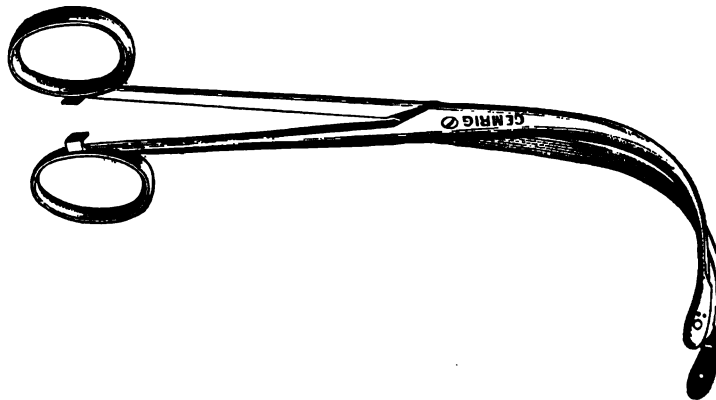
Treatment.—The only remedy for laryngeal growths is removal by operation. If left to themselves they will almost inevitably prove fatal. Of 42 cases of laryngeal tumors, tabulated by Dr. Gurdon Buck, only one was relieved by spontaneous expulsion. The majority perish from suffocation. Caustics, as nitrate of silver, chromic acid, and acid nitrate of mercury, are of no use in destroying them. The great objection to their application is that, if they are sufficiently strong to be effective, they provoke spasm of the glottis and more or less severe inflammation in the surrounding structures, thus doing harm instead of good.

Galvanic cauterization, first practised in this class of affections by Professor Middeldorpf, has occasionally yielded good results. It has been particularly extolled by Voltolini, and Reichel, of Breslau, who have reported a number of cases that are said to have been permanently relieved by it. The procedure, however, can never come into general use, as it is not only painful but difficult and tedious, requiring frequent repetition as well as costly apparatus and great skill for its successful application.

Extirpation of a morbid growth of the larynx may be effected either through the mouth, or by the oral method, as it may be termed, or by opening the windpipe, either through the thyroid cartilage, the thyro-hyoid membrane, or the crico-thyroid membrane. In the oral method, the chances of the success of the operation will be greatly increased by the previous training of the patient, so as to accustom him to keep his mouth open, to protrude his tongue, and to tolerate the manipulations and the contact of the instruments, which should always be warmed, otherwise they may cause spasm. No anæsthetic should be given, as it would only serve to embarrass the procedure and might even prove dangerous. The patient's head should be nearly perpendicular, and rest against the back of a high chair instead of being supported by an assistant, who would only be in the way of the operator. He should hold the tongue himself with his thumb and fingers, a soft napkin being interposed to prevent slipping. Chloroform may be used when the larynx is opened, for the same reason as in the operation for the removal of a foreign body from the air-passages. The after-treatment must be conducted with unusual care, by leeches and blisters, with a properly regulated temperature and other measures, the great danger after any operation, especially one involving penetration of the larynx, being from inflammation of the respiratory organs. Repullulation must be opposed with nitrate of silver, chromic acid, or sulphate of copper, cautiously applied.

When the tumor projects above the larynx, or when it is attached to the epiglottis, it may generally be torn away or twisted off with Fauvel's forceps, represented in fig. 295, or even with a more ordinary instrument; or, instead of this, it may be

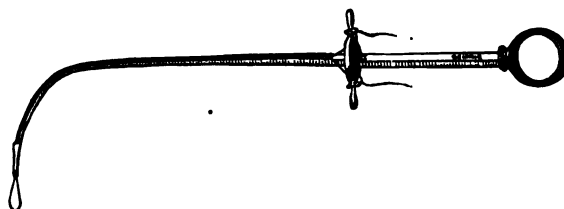
Fig. 295.



Fauvel's Forceps.

snipped off with a pair of curved scissors, or cut off with a long, slender knife, as was done by Dr. Horace Green, of New York, in 1852. When the tumor is more deeply seated, success has occasionally attended the use of the forceps, especially in the hands of a skilful operator. Small growths have frequently been removed by means

Fig. 296.



Gibb's Laryngeal Écraseur.

of a wire noose, constructed upon the principle of a double silver canula. One of the most ingenious contrivances of this kind is that devised by Sir Duncan Gibb, represented in fig. 296. It consists of a slender square bar, with a ring for the thumb at one end, and at the other a curved stem, grooved on its convex surface to within

half an inch of the point, which is perforated by two small apertures. A cross-piece slides on the bar, and serves as a support for the fore and middle fingers. A fine steel wire is passed through the holes at the extremity of the instrument, and formed into a loop, with which the tumor is caught and detached, its situation having previously been determined with the laryngoscope.

In a remarkable case of cystic tumor on the inferior surface of the epiglottis, in a boy eleven years old, Mr. Durham afforded prompt and permanent relief by a free incision through the mouth with a sharp-pointed bistoury. When such a growth occupies the interior of the larynx, it can only be approached by external incision.

Thyrotomy is indicated, if not imperatively demanded, when, the tumor being imprisoned in the larynx, and all other means of relief having failed, the patient is threatened with asphyxia. The operation, originally proposed by Desault towards the close of the last century, was performed for the first time in 1833, by Brauers, of Louvain; Ehrmann, of Strasbourg, repeated it in 1844; and, in 1851, it was performed by Dr. Gurdon Buck, of New York. The incision is carried along the middle line, from the thyroid notch to the upper border of the cricoid cartilage, through the thyroid cartilage, the division of which is effected with a short, stout, sharp-pointed knife; or, in the event of ossification, with a Hey's saw, care being taken that the separation is completed before the mucous membrane is penetrated, otherwise the blood, passing into the larynx, will, by exciting severe coughing, greatly embarrass the procedure. If sufficient room is not obtained in this way, the crico-thyroid membrane, and even a portion of the thyro-hyoid, may be divided horizontally, so as to allow the wings of the cartilage to be held properly apart, suitable retractors being at hand for this purpose. A strong reflected light being now thrown into the opening, the tumor is seized with a volsella, or pair of forceps, and snipped off with curved scissors, the base being well touched immediately after with solid nitrate of silver, to promote cicatrization, and prevent repullulation. The operation is completed by drawing the wings of the thyroid cartilage together with two silver sutures, and applying a few narrow strips of adhesive plaster across the neck in the situation of the external wound.

Of 28 cases of thyrotomy, tabulated by Dr. Mackenzie, 9 terminated fatally; and as the operation is a dangerous one, from the liability of the blood to descend into the lungs, it should always be preceded by tracheotomy, a tube being worn in the opening until the thyroid cartilages are reunited. The objections to this operation are, the risk of injuring the vocal cords and the occurrence of tracheitis, bronchitis, and pneumonitis, as immediate effects, and the remote risk of serious disease of the laryngeal cartilages and the mucous membrane of the larynx. Besides, experience has shown that the operation does not insure immunity against repullulation.

Extraction of morbid growths of the larynx has occasionally been effected through the thyro-hyoid membrane, performed according to the plan originally proposed by Malgaigne, consisting of a transverse incision carried along the lower border of the hyoid bone, through the skin, the fascia, and the inner half of the sterno-hyoid muscles. The procedure, although sufficiently easy of execution, can rarely be required, as, in the very class of cases to which it is applicable, removal can usually be effected through the fauces. Its advantage over thyrotomy is that it does not interfere with the vocal cords, but, on the other hand, there is danger, if the incision be carried high up, of wounding the epiglottis.

Removal of laryngeal growths by crico-thyrotomy, originally suggested by Czermak, has been practised successfully by Burow and Mackenzie; but the procedure has little to recommend it. The operation is performed in the same manner as in ordinary laryngotomy, but the opening is made much larger and a canula is worn for a few days before an attempt is made to effect evulsion, it being desirable that all the tenderness and tendency to hemorrhage should have subsided.

IX.—CARCINOMA.

Carcinoma of the larynx may originate in the tube itself, as a primary affection, or it may simply be an extension of the disease from the neighboring structures, as the tongue, fauces, palate, or tonsils. The most common form in which it presents itself is the epithelial. Scirrhus and encephaloid are very uncommon, especially the former. Occasionally the disease is entirely limited to the epiglottis, as in the remarkable example recorded by Sir Astley Cooper, in which an encephaloid growth, the size

of a hen's egg, sprung from the under surface of this valve-like body. It was removed twice with the finger, and finally caused fatal hemorrhage. A somewhat similar case has been related by Aronssohn. Epithelioma usually occurs in the form of an excrescence, of a rosaceous or florid color, of a tolerably firm consistence, and of varying dimensions, from that of a hazelnut up to that of a pigeon's egg. The disease, in whatever form it may occur, is most common in elderly subjects, is rather tardy in its progress, and is generally so obscure in its character as to be detected with difficulty during life. The most prominent symptoms are dyspnoea, aphonia, pain in the laryngeal region, and difficulty of deglutition. In most cases, the diagnosis can only be satisfactorily determined with the aid of the laryngoscope and the microscope.

Palliative treatment only is indicated. Tracheotomy may be performed when the patient, otherwise in tolerably good health, is threatened with suffocation. When the growth occupies the epiglottis, or the mouth of the larynx, portions of it may advantageously, as a measure of temporary relief, be torn away with the finger or forceps. Speedy repullulation must, of course, follow, and the attendant hemorrhage might be so abundant as to destroy life.

X.—SPASM.

Spasm of the larynx, or of the larynx and trachea, may be produced by a great variety of causes, some of them directly connected with the air passages, and others indirectly, consisting, perhaps, in some disease of the brain or spinal cord, or some functional disorder of the œsophagus, stomach, bowels, or uterus. Violent dyspnoea occasionally results from an aneurism of the arch of the aorta, or from a tumor in the upper part of the chest, compressing and interfering with the recurrent nerves.

Persons are sometimes instantly suffocated from the ingress of a foreign body into the windpipe, or from its lodgment upon the rima of the glottis. In such a case, the respiration may be permanently arrested in a moment, as effectually as from the administration of prussic acid, or a severe blow upon the head.

Inebriated persons occasionally die in the same manner during attempts at vomiting. In the exhausted condition of the system, consequent upon the inordinate use of ardent spirits, the contents of the stomach are lazily ejected, thus allowing some of the ingesta, as they proceed upwards, to lodge against the rima of the glottis, or even to descend into the windpipe. Diseases of the epiglottis, disqualifying it for the due performance of its functions, remarkably predispose to this occurrence.

The effect of the passage of a drop of water into the larynx is familiar to every one. All fluids, however mild, are capable, when introduced into this tube, of exciting dyspnoea, and the most violent, spasmodic, and suffocative cough; but the impression is evanescent, for the reason that the accident does not produce mechanical obstruction to respiration. The moment the spasm subsides, the breathing is reëstablished. All solid articles, on the contrary, whatever may be their character, will, by entering the windpipe, or resting against the mouth of the larynx, endanger life by suffocation.

A person laboring under delirium tremens, and confined so as to be unable to move, may, in an effort at vomiting, instantaneously perish from the introduction of food into the air-passages. Suffocation is occasionally produced by the sudden ingress of blood into the windpipe, as during operations upon the mouth and throat, and even during the performance of tracheotomy itself.

Violent, and, indeed, fatal effects are occasionally produced by the impaction of foreign bodies in the pharynx and œsophagus. In most cases, the bad effects are caused by the spasm which the extraneous substance induces in the muscles of the larynx; but occasionally it proceeds from sheer mechanical obstruction.

In the treatment of spasmodic affections of the air-passages, careful inquiry should be made into the nature of the exciting cause, for it is only by doing this that the practitioner may hope to devise a rational plan of cure. The general health, if at fault, must be amended, the secretions corrected, and all sources of irritation, local and general, removed. As means of immediate or temporary relief, the most suitable remedies are antispasmodics, particularly chloroform, morphia, and valerian, with anodyne fomentations to the neck, or, what is generally more efficacious, cloths wrung out of iced water. If the case is urgent, threatening suffocation, the only

resource is laryngotomy. No operation of this kind should, of course, be performed when the dyspnœa depends upon hysteria, dentition, or an aneurism of the arch of the aorta.

XI.—PARALYSIS.

Paralysis of the larynx occurs in two varieties of form, the traumatic and the idiopathic, the former being not unfrequently associated with paralysis of the trachea. Idiopathic paralysis of the larynx generally depends upon debility of the adductor muscles of the vocal cords, induced by impairment of the nervous system, undue exertion of the voice, or the effects of inflammation. In many cases, the affection seems to be of a purely hysterical nature, consisting in a want of consonance between the brain and the laryngeal muscles, and not in what may be strictly regarded as a want of power in the vocal organs, the disease being analogous to what is known as hysterical retention of the urine, a disorder rather of the mind than of the bladder. The paralysis may be transient or permanent, partial or complete; and, as it is always associated with loss of voice, it is generally described as "phonic paralysis." The permanent form is commonly due to organic disease of the laryngeal or pneumogastric nerves, caused by inflammatory deposits, or by the compression of some neighboring tumor, as an aneurism, an enlarged lymphatic gland, or some morbid growth.

Whatever the cause may be, it will be found, when the tube is examined with the laryngoscope, that the vocal cords, during the effort of speaking, remain more or less widely separated; or that, even, as sometimes happens, if they approach each other rather closely, they are so completely relaxed as to render them unfit for the discharge of their functions as organs of phonation. They resemble, in fact, in this condition, the loose strings of a violin. In the hysterical form of the affection, the patient is frequently unable to speak, except in the merest whisper. In another class of cases, again, the voice, after having been entirely absent for weeks, and even months, sometimes suddenly returns, to be, perhaps, again lost in a few hours, as suddenly and unexpectedly as it came. Such attacks are most common in nervous, excitable women, the subjects of dyspepsia, anemia, disorder of the menstrual functions, or of a badly-regulated temper.

Traumatic paralysis of the larynx, or of the larynx and trachea, may be attended with such urgent symptoms as to require immediate recourse to bronchotomy, in order to rescue the patient from impending suffocation. When the suffering is less violent, the more ordinary measures, especially anodynes in full doses, will generally suffice to afford relief. In the idiopathic form of the disease, the cure must be essentially based upon the correction of the antecedent evil, tonics, exercise, and cold bathing, with the local use of nitrate of silver, electricity, and stimulating sprays, being the most reliable agents. In phonic paralysis, dependent upon a hysterical condition of the system, I have repeatedly succeeded in restoring the voice permanently by a single application of a weak solution of nitrate of silver to the mouth of the larynx. A sudden, powerful, mental impression will sometimes produce a similar effect. In some of these cases, relief may be afforded, as suggested by Dr. H. K. Oliver, of Boston, by compressing, several times a day, the wings of the thyroid cartilage, at their upper and back part, with the thumb and index finger; the object of the manipulation being the approximation and stretching of the vocal cords, thereby rendering them more tense and better adapted to the exercise of their proper functions. The success of these efforts will be materially promoted if the patient be instructed to pronounce certain letters while they are being made. Blisters, and other harsh measures, seldom, if ever, do any good in such cases.

XII.—FISTULE.

Fistule of the windpipe is occasionally congenital, as in the cases recorded by Luschka, Riecke, Jenny, and in several observed by myself; most generally, however, it is caused by wounds refusing to heal, in consequence of the overlapping of their edges, or the presence of some extraneous substance, as a piece of necrosed fibrocartilage. Its size varies, of course, in different cases; usually it is very diminutive, perhaps hardly as large as an ordinary pin's head. Its edges have a red, raw appearance, and there is usually a small quantity of mucous discharge, at once indicative of the nature of the lesion. When a fistule of the trachea has continued for a long

time, the tube above the opening is very apt to become contracted, thus interfering materially with the cure of the case.

The treatment consists in paring the edges of the opening, both in the tube and in the integument, and in approximating them by several points of the interrupted suture. The milder cases occasionally yield to gentle cauterization with the solid nitrate of silver.

XIII.—INCURVATION OF THE EPIGLOTTIS.

In this affection, the free margin of the epiglottis is curled backwards in the form of a scroll, which, by encroaching upon the mouth of the larynx, keeps up constant irritation and tickling cough, with a disposition to clear the throat of mucus, hoarseness, partial aphonia, and paroxysms of suffocation. It presents itself in various degrees, is usually caused by ulceration, either simple or specific, is most common in middle-aged and elderly persons, and is frequently associated with chronic inflammation of the larynx, tonsils, and fauces. The diagnosis is readily determined by the finger and the laryngoscope. In a case recently under my charge, in a woman, fifty years old, the suffering was most distressing, although the disease had existed only for about four months. The general health was much impaired from the loss of sleep, consequent upon the violent and incessant cough and the constant desire to clear the throat of mucus, which was secreted in large quantities.

The proper remedy for this complaint is cauterization of the laryngeal surface of the epiglottis with nitrate of silver, or, what I prefer, a weak solution of acid nitrate of mercury, repeated every fourth or fifth day. The general health should be amended; and, if there is reason to suspect a syphilitic taint of the system, recourse should be had to some of the iodides in union with bichloride of mercury. If the incurvation cannot be thus relieved, and the case assumes a threatening character, the offending portion of the epiglottis should be sliced off with the hook and probe-pointed bistoury, although such a procedure will rarely be necessary.

The epiglottis is occasionally remarkably shrivelled and contracted, or singularly attenuated and elongated, its form being altered in such a manner as to resemble the outline of a battledoor, the narrow extremity being at the mouth of the larynx. The lesion usually coexists with ulceration, and is most frequently met with in phthisical and syphilitic subjects. Sometimes the epiglottis is congenitally cleft at the centre, so as to give it a bifid appearance, a condition analogous to harelip and fissure of the palate, with which it is generally associated.

XIV.—HERNIA OF THE TRACHEA.

The trachea is liable to protrusion of its lining membrane between two of its rings, constituting what has been, absurdly enough, called "bronchial hernia." It is usually caused by severe straining; either suddenly, as occasionally happens in violent labor from forcibly holding the breath, or gradually, in consequence of loud and habitual efforts with the voice. The tumor which is thus formed is remarkable for its softness, and varies from the size of a pea to that of a pigeon's egg, increasing during exertion and diminishing under pressure. It produces no particular inconvenience, except what results from the disfigurement which it occasions. The proper remedy is steady, systematic compression, which, if it do not produce a cure, will, at all events, have the effect of preventing further increase of the affection.

XV.—INJURIES.

a. *Wounds.*—Wounds of the windpipe, although in themselves not particularly dangerous, nearly always become so, on account of the entrance of blood, thereby threatening suffocation, and of the remarkable susceptibility of the lungs, after such lesions, to inflammation. Œdema of the glottis is also liable to supervene, especially when the injury is situated high up in the larynx. Another effect that not unfrequently follows such accidents is a loss of sensibility of the glottis, in consequence of which, as stated by Mr. Erichsen, who has paid particular attention to the subject, it no longer contracts on the application of ordinary stimulants, as food and drink, but permits them to pass into the larynx, thereby inducing violent cough and serious respiratory difficulty, even although the pharynx and œsophagus retain their inte-

grity. These, then, are the great sources of peril in cases of this description, and, therefore, too much vigilance cannot be exercised in guarding against their occurrence. When the tube is completely divided, the danger is, of course, imminent, death usually following in a short time from suffocation from the ingress of blood. In a case communicated to me by Dr. James D. Maxwell, of Indiana, a child, twelve years of age, lived fifteen days in this condition. The windpipe had been completely severed between the cricoid and thyroid cartilages. The œsophagus had also been freely divided. The immediate cause of death was broncho-pneumonic inflammation. Separation of the epiglottis is also generally fatal; if the detachment is partial, the flap may become entangled in the glottis; if complete, death will be likely to happen from inanition or inflammation. Larrey and others, however, have mentioned cases in which the epiglottis was shot completely away, and yet the patients made a good recovery.

A wound of the thyroid cartilage, penetrating the larynx, is generally a serious accident, as it may be complicated with copious hemorrhage into the windpipe, or be followed by violent inflammation. The danger of such a lesion will be particularly great if, as sometimes happens, the opening extends into the vocal cords, as œdema of the glottis will then be almost sure to arise, and occasion fatal suffocation.

The arytenoid cartilages are sometimes implicated, as in the interesting case recorded by Sir Charles Bell. A man, who had cut his throat, suffered from repeated attacks of frightful dyspnoea, accompanied with a peculiar flapping sound in the top of the windpipe, for which no rational explanation could be offered. He finally died in a fit of suffocation, when it was ascertained that one of the arytenoid cartilages had been divided, the fragment hanging by a piece of mucous membrane, so as to vibrate in the chink of the glottis, like a pea in a catcall.

Gunshot wounds of the windpipe are generally mortal, although occasionally recovery takes place under circumstances apparently of the most desperate character. There is reason to believe that this tube possesses the faculty of deflecting bullets. Thus, in a case which I attended with Dr. Hooper, a man was struck by a pistol ball directly over the middle line of the neck, about two inches above the sternum, and yet there was no symptom whatever denotive of perforation of the trachea, or of serious lesion of any kind.

The *treatment* of wounds of the windpipe should be conducted by suture and position, along with strict surveillance over the lungs. Although surgeons generally are averse to the employment of the suture for such a purpose, I cannot share their fears in regard to its alleged injurious effects. It is the abuse, and not the proper use, of the remedy that does the mischief. The treatment in wounds of the larynx and trachea is always perfectly safe if approximation be postponed until all danger of internal bleeding has ceased, as it usually will in five or six hours. The needle, a very delicate one, armed with silver wire, should be passed simply through the fibrous covering of the trachea, without, of course, including any portion of its rings. The external wound is closed in the usual manner. If any of the cervical muscles are divided, their extremities should be tacked together with the needle and thread. When the larynx is opened, the sutures are carried through the perichondrium, or even through the edges of the cartilages themselves. When the epiglottis is nearly severed, the best plan will be to cut off the flap, lest, falling into the glottis, it should cause suffocation. The dressing is completed by placing the head in an easy, comfortable position, with a slight inclination forwards, and confining it there by means of a tightly fitting head-bandage, the extremities of which are secured to a broad roller encircling the upper part of the chest. The head must not be drawn too far forwards, otherwise the edges of the wound, both in the windpipe and in the soft parts, may overlap.

In a case, recently communicated to me by Dr. W. R. Van Hook, of Illinois, in which the larynx was completely severed by a razor between the cricoid and thyroid cartilages, along with a portion of the œsophagus, the parts thus treated united perfectly in less than one month. No sutures were inserted into the œsophagus. The head was confined to the chin, and cough allayed by morphia.

The advantages of the suture in wounds of the windpipe are, first, a more rapid cure, and, consequently, less danger of hemorrhage and inflammation; secondly, greater facility of administering food and drink; and, lastly, much less risk of the occurrence of stricture and fistule. Should emphysema or internal bleeding arise after the parts have been approximated, it would be easy to open the wound, to a

Fig. 290.



Ulceration of the Larynx.

Ordinarily small and shallow, they sometimes occupy a large surface, or extend to a great depth, exhibiting a frightful appearance, and destroying, in their progress, muscles, ligaments, cartilages, and everything else that comes in their way.

The symptoms of ulceration of the larynx vary according to the nature, seat, and extent of the lesion. The syphilitic form, fig. 290, from Jones and Sieveking, is generally the most severe, but the tubercular is also not unfrequently attended with much pain and distress. When the vocal cords, the ventricles, or arytenoid cartilages are involved, there will be a sense of heat and pricking in the larynx, hacking cough, a husky, wheezing, or whistling state of the voice, and difficulty of breathing, along with purulent and bloody expectoration. As the disease progresses, the voice is reduced to a mere whisper, or becomes completely extinct, severe pain is experienced in the affected parts, hectic fever supervenes, and the patient finally dies from exhaustion of the vital powers, effusion into the lungs, or constitutional irritation. The suffering is greatly aggravated when the epiglottis is seriously implicated; for there is then not only dyspnoea, with cough and change of voice, but every attempt at deglutition is attended with great

distress, if not with a feeling of instant suffocation. In the more advanced stages of the malady, whatever may be its character or situation, the difficulty of swallowing is often so extreme that life is essentially abridged by starvation, the patient being sometimes unable for days together to take even liquids.

Ulceration of the larynx is always a dangerous disease. If the more common forms are occasionally recovered from, the more aggravated nearly always prove

fatal. This is particularly true of the syphilitic and tubercular varieties, very few cases of which, especially in their more advanced stages, are ever cured under any treatment. The latter is, as a general rule, even more dangerous than the former. Serious involvement of the muscles, ligaments, and cartilages is always denotive of great danger, whatever may be the nature of the exciting cause of the lesion.

Ulceration of the epiglottis, usually the result of tertiary syphilis, may also be caused by the contact of irritating substances, as hot water, the alkalies, or corrosive sublimate, as in a case from which the annexed cut, fig. 291, was taken, and in which death followed in nine days from swallowing a large dose of this poison. The dissection revealed, besides ulceration of the epiglottis and surrounding parts, the existence of pneumonia, ulceration of the stomach, and inflammation of the entire intestinal tract. The drawing is from Jones and Sieveking.

Fig. 291.



Ulceration of the Epiglottis.

It must be obvious that the *treatment* of a disease, depending upon so many and such various causes, and the diagnosis of which is so obscure, cannot be conducted with much prospect of permanent relief. Indeed, experience has shown that temporary amelioration alone is usually to be looked for. When there is reason to believe that the lesion is owing to a syphilitic taint, mercury, iodide of potassium, nitro-muriatic acid, and kindred articles, must be employed. In ulceration, consequent upon tubercular deposits, little or nothing is to be expected from internal remedies, beyond the beneficial influence which they may exert upon the general health. In all cases, whatever may be the origin of the malady, permanent quietude of the affected organ is indispensable. Hence, the patient must refrain from all conversation, and even, as far as practicable, from deglutition. When there is much pain, soreness, or

tenderness in the parts, a few leeches may occasionally be applied to the front of the larynx, or the nape of the neck may be rendered raw with a blister. The best local remedy, however, is a solution of nitrate of silver, in the proportion of twenty to thirty grains of the salt to the ounce of water, with which the ulcerated surface should be gently but efficiently touched, in the manner above indicated, every third, fourth, or fifth day, according to the tolerance of the parts. If suffocation be threatened, tracheotomy may be performed, and a tube worn to facilitate respiration.

VII.—STRICTURE.

Stricture of the windpipe, fig. 292, may be induced by a deposit of fibrin in the mucous and submucous cellular tissues, or, as is more frequently the case, by the contraction consequent upon a wound, the healing of a large ulcer, or the death and exfoliation of a portion of one of its cartilages. Great diminution of the tube is occasionally produced by the pressure of an enlarged thyroid gland. The symptoms are those of impeded respiration, gradually increasing, and surely tending to the destruction of the patient. The diagnosis is established by the history of the case, and by a careful exploration of the tube with the probang. Relief may be attempted, although with hardly any prospect of success, by dilatation with the bougie, passed from the mouth, or from below upwards, through an opening in the trachea. The treatment is conducted on the same principle as in stricture of the urethra, œsophagus, and other mucous outlets. When the parts are very irritable, cauterization precedes the dilatation; and when the latter operation is impracticable, on account of the intractableness of the patient, control is effected by anæsthesia. In desperate cases the trachea is laid open, and a silver tube worn. By such a procedure, a patient may sometimes live in comparative comfort for many years.

Fig. 292.



Double Stricture of the Windpipe.

VIII.—TUMORS OR MORBID GROWTHS.

Morbid growths of the larynx, until recently described as polyps and warty excrescences, may be arranged, according to their anatomical characters, under the following heads: papillary, fibrous, myxomatous, sarcomatous, adenoid, cystic, lipomatous, and angiomatous, the supposed frequency of their occurrence being very much in the order here enumerated. The papillary tumor is more common than all the others together. Thus, of 100 cases observed by Dr. Morell Mackenzie, of London, 67 were of this description, and Dr. Cohen, of this city, met with 49 papillomas out of 66 morbid growths; results which tally very closely with the experience of other specialists. Compound growths, consisting of a combination of neoplastic elements, are not uncommon, the mixed structures being often so nearly balanced in quantity as to render it difficult, if not impossible, to determine which predominates. Of the carcinomatous growths of the larynx the epithelial is the most common. Encephaloid has been met with only in a few instances, and of colloid and melanosis I do not know that there are any recorded examples.

In regard to their form, tumors of the larynx exhibit great diversity; most commonly, however, they are globular, ovoidal, conical, or pyriform, and either perfectly smooth, or, as in the case of the papillary varieties, rough, granulated, or fissured upon the surface like a cauliflower, a mulberry, or a wart. Of a pale-rose, pink, red, or grayish color, they vary in consistence, according to their structure, from soft, gelatinous matter to dense fibrous tissue. Their volume ranges between that of a mustard seed and an English walnut. As it respects their mode of attachment, they are either sessile or pedunculated; more frequently the former. Their favorite seat is the interior of the larynx, at or near the vocal cords, which, in the cases observed by Mackenzie, suffered at the rate of nearly 75 per cent. Sometimes they are situated in the ventricles of Morgagni, at the root of the epiglottis, or at the border of the mouth of the larynx. Occasionally nearly the whole tube is involved. The

surface corresponding with the arytenoid cartilages enjoys a remarkable immunity from morbid growths of every description.

The papillary form of tumor is well illustrated by the annexed sketch, fig. 293; while fig. 294, from a drawing of a specimen in my collection, exhibits a fibrous

Fig. 293.



Papillary Growths of the Larynx in the Situation of the Vocal Cords.

Fig. 294.



Polypoid Fibroma of the Larynx.

growth, found in a man thirty-eight years of age, who finally died of tubercular phthisis, in a state of profound marasmus. The tumor was about the size of a filbert, and hung down into the lower part of the larynx by a rather narrow pedicle.

Morbid growths of the larynx are most common between the ages of forty and fifty; they are often met with in infancy and childhood; and cases occur in which they are either congenital, or in which they arise soon after birth. Men are much more liable to them than women. Of 287 cases, referred to by Mackenzie, 197 belonged to the male sex. Causit has collected 42 cases of laryngeal tumors occurring in early life, of which two-thirds were noticed in boys. What influence, if any, occupation exerts upon the production of these growths has not been determined. It is, however, generally believed that the constant use of the voice, as in speaking and singing, is a predisposing cause. Frequent attacks of cold, the inhalation of irritating vapors and particles of matter, chronic thickening of the mucous membrane of the larynx, and a strumous taint of the system probably act in a similar manner. Warty excrescences, or papillary tumors, are often directly traceable to the effects of the syphilitic poison.

The existence of these tumors is indicated by a sense of constriction in the larynx, alteration of the voice, croupy cough, occasional and gradually increasing dyspnoea, and more or less violent attacks of suffocation, especially when the morbid growth changes its position. There is seldom any pain. Dysphagia may be present when the tumor is unusually large, or when it is attached to the epiglottis. An alteration of the voice is one of the most constant symptoms. In old, chronic cases there is frequently either complete aphonia, or the patient is unable to speak above a mere whisper. The dyspnoea, seldom present to any extent in the earlier stages of the disease, gradually increases in intensity and frequency with the development of the tumor, and is generally of a paroxysmal character, worse at night than in the day-time, and liable to be aggravated by cold and change of posture. When cough is present, which, however, is seldom the case, it is usually dry and hacking, and often accompanied by a hoarse, croupy, or stridulous condition of the voice. Inspiration is generally more difficult than expiration; and, as the growth increases in bulk, the patient is often suddenly seized with a sense of suffocation, especially on lying down.

The *diagnosis* of laryngeal tumors can only be satisfactorily determined with the aid of the laryngoscope. Occasionally a portion of the tumor, or even the entire mass, is detached and ejected, thus, of course, dispelling all doubt respecting the nature of the disease. Among the more reliable rational symptoms are, the altered state of the voice and the violent attacks of dyspnoea, generally coming on suddenly and unexpectedly. When the growth is very pendulous, or attached by a long, narrow pedicle, it sometimes produces a flapping, valvular sound, as it moves about during respiration or change of posture. When the tumor is situated above the vocal cords, the voice will be likely to be noisy and stridulous; whereas, when the cords themselves are affected, aphonia will be present. Simple ocular inspection is sometimes sufficient to detect the morbid growth; only, however, when it is situated high up, or when it is connected with the epiglottis. Under similar circumstances a digital exploration may occasionally be advantageously made, as it may serve to determine the consistence and mode of attachment of the tumor.

To ascertain the size and position of the growth a laryngoscopic examination, repeated perhaps several times on different days, is essentially necessary, more especially if the parts are very irritable, or the patient does not properly coöperate with the surgeon. In trying to determine the nature of the tumor the chief points to be attended to are, its color, its consistence, and the appearance of its surface. Unfortunately, however, if we exclude the papillary and fibrous tumors, little light is to be obtained from such a mode of investigation, and even these do not always furnish very satisfactory data as it respects their precise characters. The papilloma is generally distinguished by its pink or reddish hue, its mamillary, fimbriated, or wart-like surface, its sessile base, its small size, the rapidity of its growth, and its great frequency in young subjects. The fibroma, which is next in the order of frequency after the papilloma, has a smooth and somewhat wavy surface, and is of a red color, round, oval, or pyriform in shape, and notably pedunculated, the latter forming one of its most characteristic features. Fatty, mucous, adenoid, vascular, and sarcomatous growths of the larynx do not furnish any diagnostic signs. The cystic tumor has a white, jelly-like appearance, not unlike a ranula, and is of a soft consistence, hemispherical in form, and encircled by a hyperemic condition of the adjacent surface.

The distinction between benign and malignant growths of the larynx is generally easy, the differentiation being based mainly upon the history of the case and the fact that the latter have generally a much broader attachment than the former. Moreover, if the disease has made considerable progress, the surface of the tumor will usually be found to be more or less ulcerated.

Gummy syphilitic tumors are most commonly met with on the posterior wall of the larynx, within the first three months after the occurrence of the primary sore, and they generally present themselves as slightly raised prominences, of a whitish or pale, yellowish color, strikingly contrasting with the red and injected mucous surface in their immediate vicinity. The coexistence of syphilitic disease in other parts of the body will assist the diagnosis.

Eversion of the mucous membrane of the ventricle of the larynx is mentioned by Mackenzie and others as an occasional source of error of diagnosis. The occurrence, however, is extremely rare, and a careful examination will generally readily dispel any doubt that may exist upon the subject.

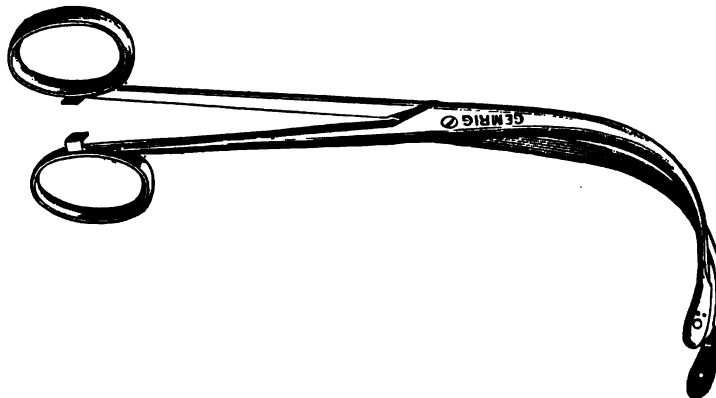
Treatment.—The only remedy for laryngeal growths is removal by operation. If left to themselves they will almost inevitably prove fatal. Of 42 cases of laryngeal tumors, tabulated by Dr. Gurdon Buck, only one was relieved by spontaneous expulsion. The majority perish from suffocation. Caustics, as nitrate of silver, chromic acid, and acid nitrate of mercury, are of no use in destroying them. The great objection to their application is that, if they are sufficiently strong to be effective, they provoke spasm of the glottis and more or less severe inflammation in the surrounding structures, thus doing harm instead of good.

Galvanic cauterization, first practised in this class of affections by Professor Middeldorpf, has occasionally yielded good results. It has been particularly extolled by Voltolini, and Reichel, of Breslau, who have reported a number of cases that are said to have been permanently relieved by it. The procedure, however, can never come into general use, as it is not only painful but difficult and tedious, requiring frequent repetition as well as costly apparatus and great skill for its successful application.

Extirpation of a morbid growth of the larynx may be effected either through the mouth, or by the oral method, as it may be termed, or by opening the windpipe, either through the thyroid cartilage, the thyro-hyoid membrane, or the crico-thyroid membrane. In the oral method, the chances of the success of the operation will be greatly increased by the previous training of the patient, so as to accustom him to keep his mouth open, to protrude his tongue, and to tolerate the manipulations and the contact of the instruments, which should always be warmed, otherwise they may cause spasm. No anæsthetic should be given, as it would only serve to embarrass the procedure and might even prove dangerous. The patient's head should be nearly perpendicular, and rest against the back of a high chair instead of being supported by an assistant, who would only be in the way of the operator. He should hold the tongue himself with his thumb and fingers, a soft napkin being interposed to prevent slipping. Chloroform may be used when the larynx is opened, for the same reason as in the operation for the removal of a foreign body from the air-passages. The after-treatment must be conducted with unusual care, by leeches and blisters, with a properly regulated temperature and other measures, the great danger after any operation, especially one involving penetration of the larynx, being from inflammation of the respiratory organs. Repullulation must be opposed with nitrate of silver, chromic acid, or sulphate of copper, cautiously applied.

When the tumor projects above the larynx, or when it is attached to the epiglottis, it may generally be torn away or twisted off with Fauvel's forceps, represented in fig. 295, or even with a more ordinary instrument; or, instead of this, it may be

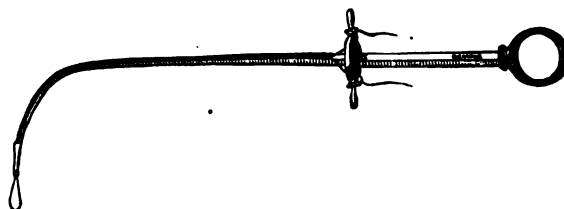
Fig. 295.



Fauvel's Forceps.

snipped off with a pair of curved scissors, or cut off with a long, slender knife, as was done by Dr. Horace Green, of New York, in 1852. When the tumor is more deeply seated, success has occasionally attended the use of the forceps, especially in the hands of a skilful operator. Small growths have frequently been removed by means

Fig. 296.



Gibb's Laryngeal Éraseur.

of a wire noose, constructed upon the principle of a double silver canula. One of the most ingenious contrivances of this kind is that devised by Sir Duncan Gibb, represented in fig. 296. It consists of a slender square bar, with a ring for the thumb at one end, and at the other a curved stem, grooved on its convex surface to within

half an inch of the point, which is perforated by two small apertures. A cross-piece slides on the bar, and serves as a support for the fore and middle fingers. A fine steel wire is passed through the holes at the extremity of the instrument, and formed into a loop, with which the tumor is caught and detached, its situation having previously been determined with the laryngoscope.

In a remarkable case of cystic tumor on the inferior surface of the epiglottis, in a boy eleven years old, Mr. Durham afforded prompt and permanent relief by a free incision through the mouth with a sharp-pointed bistoury. When such a growth occupies the interior of the larynx, it can only be approached by external incision.

Thyrotomy is indicated, if not imperatively demanded, when, the tumor being imprisoned in the larynx, and all other means of relief having failed, the patient is threatened with asphyxia. The operation, originally proposed by Desault towards the close of the last century, was performed for the first time in 1833, by Brauers, of Louvain; Ehrmann, of Strasbourg, repeated it in 1844; and, in 1851, it was performed by Dr. Gurdon Buck, of New York. The incision is carried along the middle line, from the thyroid notch to the upper border of the cricoid cartilage, through the thyroid cartilage, the division of which is effected with a short, stout, sharp-pointed knife; or, in the event of ossification, with a Hey's saw, care being taken that the separation is completed before the mucous membrane is penetrated, otherwise the blood, passing into the larynx, will, by exciting severe coughing, greatly embarrass the procedure. If sufficient room is not obtained in this way, the crico-thyroid membrane, and even a portion of the thyro-hyoid, may be divided horizontally, so as to allow the wings of the cartilage to be held properly apart, suitable retractors being at hand for this purpose. A strong reflected light being now thrown into the opening, the tumor is seized with a volsella, or pair of forceps, and snipped off with curved scissors, the base being well touched immediately after with solid nitrate of silver, to promote cicatrization, and prevent repullulation. The operation is completed by drawing the wings of the thyroid cartilage together with two silver sutures, and applying a few narrow strips of adhesive plaster across the neck in the situation of the external wound.

Of 28 cases of thyrotomy, tabulated by Dr. Mackenzie, 9 terminated fatally; and as the operation is a dangerous one, from the liability of the blood to descend into the lungs, it should always be preceded by tracheotomy, a tube being worn in the opening until the thyroid cartilages are reunited. The objections to this operation are, the risk of injuring the vocal cords and the occurrence of tracheitis, bronchitis, and pneumonitis, as immediate effects, and the remote risk of serious disease of the laryngeal cartilages and the mucous membrane of the larynx. Besides, experience has shown that the operation does not insure immunity against repullulation.

Extraction of morbid growths of the larynx has occasionally been effected through the thyro-hyoid membrane, performed according to the plan originally proposed by Malgaigne, consisting of a transverse incision carried along the lower border of the hyoid bone, through the skin, the fascia, and the inner half of the sterno-hyoid muscles. The procedure, although sufficiently easy of execution, can rarely be required, as, in the very class of cases to which it is applicable, removal can usually be effected through the fauces. Its advantage over thyrotomy is that it does not interfere with the vocal cords, but, on the other hand, there is danger, if the incision be carried high up, of wounding the epiglottis.

Removal of laryngeal growths by crico-thyrotomy, originally suggested by Czermak, has been practised successfully by Burow and Mackenzie; but the procedure has little to recommend it. The operation is much performed in the same manner as in ordinary laryngotomy, but the opening is made much larger and a canula is worn for a few days before an attempt is made to effect evulsion, it being desirable that all the tenderness and tendency to hemorrhage should have subsided.

IX.—CARCINOMA.

Carcinoma of the larynx may originate in the tube itself, as a primary affection, or it may simply be an extension of the disease from the neighboring structures, as the tongue, fauces, palate, or tonsils. The most common form in which it presents itself is the epithelial. Scirrhus and encephaloid are very uncommon, especially the former. Occasionally the disease is entirely limited to the epiglottis, as in the remarkable example recorded by Sir Astley Cooper, in which an encephaloid growth, the size

time, the tube above the opening is very apt to become contracted, thus interfering materially with the cure of the case.

The treatment consists in paring the edges of the opening, both in the tube and in the integument, and in approximating them by several points of the interrupted suture. The milder cases occasionally yield to gentle cauterization with the solid nitrate of silver.

XIII.—INCURVATION OF THE EPIGLOTTIS.

In this affection, the free margin of the epiglottis is curled backwards in the form of a scroll, which, by encroaching upon the mouth of the larynx, keeps up constant irritation and tickling cough, with a disposition to clear the throat of mucus, hoarseness, partial aphonia, and paroxysms of suffocation. It presents itself in various degrees, is usually caused by ulceration, either simple or specific, is most common in middle-aged and elderly persons, and is frequently associated with chronic inflammation of the larynx, tonsils, and fauces. The diagnosis is readily determined by the finger and the laryngoscope. In a case recently under my charge, in a woman, fifty years old, the suffering was most distressing, although the disease had existed only for about four months. The general health was much impaired from the loss of sleep, consequent upon the violent and incessant cough and the constant desire to clear the throat of mucus, which was secreted in large quantities.

The proper remedy for this complaint is cauterization of the laryngeal surface of the epiglottis with nitrate of silver, or, what I prefer, a weak solution of acid nitrate of mercury, repeated every fourth or fifth day. The general health should be amended; and, if there is reason to suspect a syphilitic taint of the system, recourse should be had to some of the iodides in union with bichloride of mercury. If the incurvation cannot be thus relieved, and the case assumes a threatening character, the offending portion of the epiglottis should be sliced off with the hook and probe-pointed bistoury, although such a procedure will rarely be necessary.

The epiglottis is occasionally remarkably shrivelled and contracted, or singularly attenuated and elongated, its form being altered in such a manner as to resemble the outline of a battledoor, the narrow extremity being at the mouth of the larynx. The lesion usually coexists with ulceration, and is most frequently met with in phthisical and syphilitic subjects. Sometimes the epiglottis is congenitally cleft at the centre, so as to give it a bifid appearance, a condition analogous to harelip and fissure of the palate, with which it is generally associated.

XIV.—HERNIA OF THE TRACHEA.

The trachea is liable to protrusion of its lining membrane between two of its rings, constituting what has been, absurdly enough, called "bronchial hernia." It is usually caused by severe straining; either suddenly, as occasionally happens in violent labor from forcibly holding the breath, or gradually, in consequence of loud and habitual efforts with the voice. The tumor which is thus formed is remarkable for its softness, and varies from the size of a pea to that of a pigeon's egg, increasing during exertion and diminishing under pressure. It produces no particular inconvenience, except what results from the disfigurement which it occasions. The proper remedy is steady, systematic compression, which, if it do not produce a cure, will, at all events, have the effect of preventing further increase of the affection.

XV.—INJURIES.

a. *Wounds*.—Wounds of the windpipe, although in themselves not particularly dangerous, nearly always become so, on account of the entrance of blood, thereby threatening suffocation, and of the remarkable susceptibility of the lungs, after such lesions, to inflammation. Oedema of the glottis is also liable to supervene, especially when the injury is situated high up in the larynx. Another effect that not unfrequently follows such accidents is a loss of sensibility of the glottis, in consequence of which, as stated by Mr. Erichsen, who has paid particular attention to the subject, it no longer contracts on the application of ordinary stimulants, as food and drink, but permits them to pass into the larynx, thereby inducing violent cough and serious respiratory difficulty, even although the pharynx and œsophagus retain their inte-

grity. These, then, are the great sources of peril in cases of this description, and, therefore, too much vigilance cannot be exercised in guarding against their occurrence. When the tube is completely divided, the danger is, of course, imminent, death usually following in a short time from suffocation from the ingress of blood. In a case communicated to me by Dr. James D. Maxwell, of Indiana, a child, twelve years of age, lived fifteen days in this condition. The windpipe had been completely severed between the cricoid and thyroid cartilages. The œsophagus had also been freely divided. The immediate cause of death was broncho-pneumonic inflammation. Separation of the epiglottis is also generally fatal; if the detachment is partial, the flap may become entangled in the glottis; if complete, death will be likely to happen from inanition or inflammation. Larrey and others, however, have mentioned cases in which the epiglottis was shot completely away, and yet the patients made a good recovery.

A wound of the thyroid cartilage, penetrating the larynx, is generally a serious accident, as it may be complicated with copious hemorrhage into the windpipe, or be followed by violent inflammation. The danger of such a lesion will be particularly great if, as sometimes happens, the opening extends into the vocal cords, as œdema of the glottis will then be almost sure to arise, and occasion fatal suffocation.

The arytenoid cartilages are sometimes implicated, as in the interesting case recorded by Sir Charles Bell. A man, who had cut his throat, suffered from repeated attacks of frightful dyspnoea, accompanied with a peculiar flapping sound in the top of the windpipe, for which no rational explanation could be offered. He finally died in a fit of suffocation, when it was ascertained that one of the arytenoid cartilages had been divided, the fragment hanging by a piece of mucous membrane, so as to vibrate in the chink of the glottis, like a pea in a catcall.

Gunshot wounds of the windpipe are generally mortal, although occasionally recovery takes place under circumstances apparently of the most desperate character. There is reason to believe that this tube possesses the faculty of deflecting bullets. Thus, in a case which I attended with Dr. Hooper, a man was struck by a pistol ball directly over the middle line of the neck, about two inches above the sternum, and yet there was no symptom whatever denotive of perforation of the trachea, or of serious lesion of any kind.

The treatment of wounds of the windpipe should be conducted by suture and position, along with strict surveillance over the lungs. Although surgeons generally are averse to the employment of the suture for such a purpose, I cannot share their fears in regard to its alleged injurious effects. It is the abuse, and not the proper use, of the remedy that does the mischief. The treatment in wounds of the larynx and trachea is always perfectly safe if approximation be postponed until all danger of internal bleeding has ceased, as it usually will in five or six hours. The needle, a very delicate one, armed with silver wire, should be passed simply through the fibrous covering of the trachea, without, of course, including any portion of its rings. The external wound is closed in the usual manner. If any of the cervical muscles are divided, their extremities should be tacked together with the needle and thread. When the larynx is opened, the sutures are carried through the perichondrium, or even through the edges of the cartilages themselves. When the epiglottis is nearly severed, the best plan will be to cut off the flap, lest, falling into the glottis, it should cause suffocation. The dressing is completed by placing the head in an easy, comfortable position, with a slight inclination forwards, and confining it there by means of a tightly fitting head-bandage, the extremities of which are secured to a broad roller encircling the upper part of the chest. The head must not be drawn too far forwards, otherwise the edges of the wound, both in the windpipe and in the soft parts, may overlap.

In a case, recently communicated to me by Dr. W. R. Van Hook, of Illinois, in which the larynx was completely severed by a razor between the cricoid and thyroid cartilages, along with a portion of the œsophagus, the parts thus treated united perfectly in less than one month. No sutures were inserted into the œsophagus. The head was confined to the chin, and cough allayed by morphia.

The advantages of the suture in wounds of the windpipe are, first, a more rapid cure, and, consequently, less danger of hemorrhage and inflammation; secondly, greater facility of administering food and drink; and, lastly, much less risk of the occurrence of stricture and fistule. Should emphysema or internal bleeding arise after the parts have been approximated, it would be easy to open the wound, to a

small extent in front, both in the integument and in the windpipe, and even to introduce a canula, until all danger from these causes has subsided.

The after-treatment is strictly antiphlogistic. The tongue is frequently moistened with iced water; food and drink are, if necessary, conveyed into the stomach by means of a suitable tube, passed through the mouth; and the bowels are moved by enemata. In very bad cases, involving serious lesion of the pharynx or œsophagus, life must be sustained by beef essence, brandy, and other means, introduced by the rectum. Cough is allayed, and sleep induced, by morphia. The head and shoulders are elevated, and the dressings are disturbed as little as possible, the sutures being retained as long as they may seem to do good. Pulmonic and bronchial involvement are met by the usual means. The temperature of the patient's apartment is regulated by the thermometer, and constantly kept at 80° of Fahrenheit. The admission of cold air, especially through the wound, cannot fail to be pernicious, from its tendency to awaken cough and inflammation of the respiratory organs. The patient must be watched with the greatest possible assiduity. If he is suicidally inclined, he must be put in the straight jacket, otherwise he will be sure to tear away the dressings, and open the wound, if he do not inflict other mischief.

Danger may arise during the treatment of laryngeal wounds, from the formation of exuberant granulations, which, extending into the interior of the tube, may so encroach upon it as to cause excessive dyspnoea, if not fatal obstruction. The proper remedy is the removal of the redundant material with the scissors, and afterwards effectually cauterizing the raw surfaces with nitrate of silver. If this treatment fail, recourse must be had to tracheotomy, the incision being kept open until thorough cicatrization is effected.

β. Laceration.—Laceration of the windpipe is occasionally met with, generally as the result of a blow, kick, or fall upon the neck, without any external wound, and is always a dangerous accident, imperilling life by paralysis of the air-passages, spasm of the glottis, or suffocation from emphysema. Of 13 cases, collected by Dr. Fischer, of Hannover, in 7 of which the trachea alone was involved, only 2 recovered, the tube having been opened in one. The remaining 6, which were complicated with fracture of the laryngeal cartilages or the hyoid bone, perished. In a case observed by Dr. John L. Atlee, the patient, a boy, aged four years, perished from emphysema in less than fifteen minutes after the receipt of the injury, produced by striking his neck forcibly against a door-scraper. The air, under such circumstances, escapes from the wounded parts into the cellular tissue of the cervical region, from which it spreads more or less rapidly over the head, trunk, and even the upper extremities, followed by frightful dyspnoea, and, if succor is not promptly afforded, by death.

These injuries may affect both the larynx and the trachea, the former apparently more frequently than the latter. Laceration of the trachea alone may be caused by a sudden and violent effort at inspiration after the integrity of the tube has been impaired by atrophy and ulceration, as in an instance reported to me by Dr. Thomas Marshall, of Kentucky. Coughing has been known to produce a similar accident, a case having been recorded by Bredschneider in a child, twenty-one months of age, affected with bronchitis. The occurrence was denoted by emphysema of the neck and chest, and the tube was found to be ruptured to the extent of six lines below the first ring.

The proper remedy in these injuries is obviously tracheotomy, performed without a moment's delay, especially if there is a rapid escape of air into the surrounding structures. In fact, in case of extreme urgency, the operation should be attempted even if the patient is in the act of dying, or has actually ceased to breathe. The wound should be kept open with a suitable tube, the head maintained in a fixed position, and every effort made to allay spasm and prevent the occurrence of severe inflammation. The skin must be freely punctured, if there is extensive emphysema.

Tracheotomy is not a new operation in this class of injuries. Habicot performed it successfully, in 1594, upon a man whose thyroid cartilage had been struck by a bullet, causing such an amount of dyspnoea as to threaten suffocation. Liston resorted to it in 1823, and since that time it has occasionally been employed by others.

γ. Contusion.—Contusion of the windpipe, especially of the larynx, is sometimes followed by very unpleasant symptoms. Such an accident, in fact, may prove suddenly fatal from closure of the rima of the glottis, in consequence of spasm of the

laryngeal muscles. The exciting cause is generally a blow or fall upon the neck; and the proper remedy, in case of urgency, is laryngotomy, performed without a moment's delay, a tube being retained in the wound until thorough relief is obtained. When the symptoms are less severe, the chief reliance should be upon antiphlogistics, as leeches, blisters, purgatives, and tartar emetic in union with morphia. If the patient remains aphonic for a long time, recourse should be had to mercury, in alterative and frequently-repeated doses, with stimulating embrocations to the neck.

8. *Fracture of the Larynx.*—The cartilages of the larynx may be broken by external violence, as a fall or a blow, the kick of a horse, or the pressure of the thumb and fingers. The accident is most common in elderly subjects, after partial ossification of these bodies, and the one which is most liable to suffer is the thyroid. Of 27 cases analyzed by Dr. William Hunt, of this city, including one observed by himself, only 5 were in children. The fracture may be simple, comminuted, or complicated. The only reliable diagnostic symptoms are crepitation, displacement of the fragments, and preternatural mobility. The ordinary accompaniments are difficulty of articulation, breathing, and deglutition, loss of voice, cough, hemorrhage, and emphysema, from an escape of air into the surrounding cellular tissue. The discrimination may be rendered very difficult, if not impracticable, by great tumefaction of the neck.

Most of the cases of this accident prove fatal either soon after its occurrence from suffocation, or more or less remotely from the effects of inflammation. Of the 27 cases analyzed by Dr. Hunt, 17 died. In 8 laryngotomy was performed, with 2 deaths, and 6 recoveries. More extended observations show even a greater mortality. Thus, of 62 cases collected by Hénocque and Durham, 50 died, and 12 got well, tracheotomy having been performed in eight. In every instance, 21 in number, in which the cricoid cartilage was fractured, the result was fatal.

Fracture of the laryngeal cartilages, unless attended with serious displacement, requires little else than the ordinary antiphlogistic measures, with perfect quietude of the head, neck, and tongue. When the symptoms are urgent, threatening suffocation, the proper remedy is tracheotomy performed with the least possible delay. The larynx may be opened when there is extensive separation of the fragments, as such a procedure would afford greater facilities for effecting replacement; but ordinarily tracheotomy deserves the preference. If the orifice is sufficiently large, there will be no need of a tube. In a case, reported in 1866, by Professor Maclean, of Kingston, Canada, tracheotomy was rendered necessary, and was successfully performed, on account of œdema of the glottis consequent upon a comminuted fracture of the thyroid cartilage, attended with excessive apnœa, dysphagia, and emphysema of the neck.

9. *Scalds of the Larynx.*—Scalds of the larynx may be caused by the inhalation of steam or the contact of hot fluids, the subjects of the accident being usually very young children. Intense pain, restlessness, and difficulty of swallowing, followed by impeded respiration dependent upon œdema of the glottis, and broncho-pulmonary congestion are the characteristic symptoms of the occurrence. The mouth, tongue, and fauces are red, as well as here and there vesicated, and evidences of the effects of hot fluid also frequently exist upon the cheeks. The epiglottis is hard, round, and contracted, as if it had been scorched. In the worst forms of the accident, the voice is croupy, sonorous râles are heard over the chest, the countenance is of a purplish hue, the pulse is rapid and feeble, the surface is cold and damp, the eyes are rolled up, the pupils are dilated, and the patient is semicomatose. If prompt relief be not obtained, death ensues from spasm of the larynx, or from the joint influence of spasm and inflammation, the latter often extending to the bronchial tubes and to the substance of the lungs.

The kind of treatment must depend upon the violence and extent of the injury. The milder cases will generally readily yield to ordinary antiphlogistic measures, as an active purgative, a gentle emetic to expel the redundant mucous secretion, and leeches to the neck, or the upper part of the sternum. When the symptoms are urgent, tracheotomy should be performed, as it is frequently the only chance of prolonging or saving life, although the result is generally unfavorable, as is shown by the statistics of Mr. Durham, in which, out of 28 cases, only 5 recovered.

Professor Bevan, of Dublin, has met with four cases of scalds of the larynx all

successfully treated by emetics, leeches to the upper part of the sternum, and calomel, in doses of one to two grains every half hour, until free bilious evacuations were produced.

XVI.—FOREIGN BODIES.

The air-passages are liable to the intrusion of a great variety of substances, referable to four distinct classes, vegetable, animal, mineral, and mixed, the latter comprising such as are partly vegetable and partly animal, partly animal and partly mineral, or partly mineral and partly vegetable. Of these different substances, those which most commonly enter the air-passages, at least in this country, are grains of corn, beans, melon-seeds, pebbles, and cherry-stones. Bits of meat, bone, and gristle are also frequent intruders. Pieces of coin, pins, buttons, and similar articles are extremely liable to be entrapped in the windpipe, in consequence, apparently, of the foolish habit, so common everywhere, of holding such substances heedlessly in the mouth. I am acquainted with a number of cases, one of which fell under my own observation, in which the foreign body was a cockle-bur, represented in fig. 297. Substances of extraordinary size sometimes pass into the air-tubes. Thus, in the case of a child between three and four years of age, communicated to me by Dr. Foote, of Indiana, the foreign body, a brass pen-holder, was

Fig. 297.



Cockle-bur.

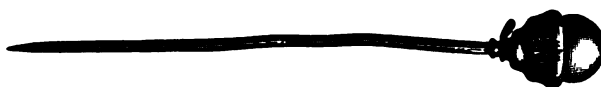
Fig. 298.



Ear of Grass.

three inches and a half in length by three lines in diameter. It had descended into the left bronchial tube, where it was found after death, nine months after the accident, surrounded by thick matter. Several instances have been reported of the accidental inhalation of the ears of rye, wheat, barley, and grass, as in fig. 298. Dr. J. C. Reeve, of Ohio, in 1869, extracted by tracheotomy, from a little girl, a shawl-pin, fig. 299, upwards of three inches in length. Worms, especially the lum-

Fig. 299.



bricoid variety, have been known to creep into the windpipe; and at least one man has lost his life from the introduction of a leech into the sinus of the larynx. Gautier has reported a case of death from the inhalation of a small fish.

In my Treatise on Foreign Bodies in the Air-Passages, published in 1854, a number of cases are mentioned in which teeth, both natural and artificial, were inhaled. In several of the cases, the artificial teeth were connected together by metal, as in fig. 300. In this instance, the substance was retained for thirteen years, and was found, on dissection, in the right thoracic cavity, into which it had passed by ulceration. Mr. Nunn attended a man who drew a puff-dart, represented in fig. 301, into his windpipe. Occasionally, the entrapped substance has been a bullet, as in two instances, reported to me, respectively, by Dr. Maxwell, of Indiana, and by Dr. Stitt, of Kentucky. A case occurred in this city, in 1867, in which a man, twenty-three years of age, lost his life from the inhalation of a cork during the extraction of a molar tooth while under the influence of nitrous oxide gas. The cork had been placed between the jaws, and was found by Dr. Shapleigh after death, which hap-

pened within less than two hours after the accident, in the lower extremity of the trachea. The specimen is in my cabinet. Dr. Underhill has reported a case in which the foreign body consisted of the copper tip of an umbrella; and Dr. G. Buck one of a hard rubber tube, upwards of two inches and a half in length by six lines in diameter.

Fig. 300.



Artificial Teeth.

Fig. 301.



Puff-dart.

Two, three, and even four foreign substances sometimes enter the air-tubes, either simultaneously or successively. Dr. Sipe, of Missouri, has communicated to me the particulars of the case of a child, who, when the larynx was opened, ejected not less than a dozen fragments of parched corn. Dr. Mount, of Cincinnati, met with an instance, in an infant five weeks old, who, after the operation of laryngo-tracheotomy, expelled four pieces of unburnt coffee, three immediately, and the other and largest one the next day. Sometimes the substances are of a dissimilar character. Thus, in a case observed by Professor Van Buren, the child, upon the windpipe being opened, coughed up a water-melon seed and the shank of a plum.

Situation.—The foreign body may be arrested in different portions of the windpipe, or it may remain loose, and move up and down the canal during the expulsion and introduction of the air. Occasionally, it is stopped at the very entrance of the larynx; but more frequently, by far, it passes into the interior of the tube, and lodges in one of its ventricles. It is not often arrested in the trachea, or, if arrested, it does not long remain there. Instead of this, after having passed the larynx, it generally, either at once or at a very early period, descends into one of the bronchial tubes, from which, however, during a violent expiratory effort, it may again be expelled upwards, not only into the trachea, but even into the larynx. A needle, pin, or bit of bone, or, in short, any sharp and slender body, might be permanently retained in the trachea, in consequence of its extremities becoming implanted in its walls; so also might a cockle-bur, a piece of meat, a lump of cheese, or a piece of sponge. A solid or a heavy body, as a bullet, pebble, shot, or grain of corn, will, on the contrary, be almost certain to pass at once into the bronchial tubes, in obedience simply to the laws of gravity. A case in which seven artificial teeth, set in gutta-percha, were arrested at the junction of the larynx and trachea, has been recorded by Mr. Henry G. Croly, of Dublin.

When a foreign body passes into the bronchial tubes, its tendency is to lodge in the right; a circumstance which has long been known, and variously explained. Thus, it has been supposed to be owing to the differences in the capacity and direction of the two tubes, the right being larger than the left and placed more horizontally. The real cause, however, would seem to be the ridge, or spur, in the lower part of the trachea, the position of which, towards the left of the mesial plane, has the effect of throwing the foreign body, as it descends, over towards the right side, an effect still further favored by the greater diameter of the passage. Sometimes, each bronchial tube contains a foreign body; and occasionally, again, although rarely, the substance is forced on beyond the primitive division into a secondary one.

The glottis, although by far the most common, is not the only avenue by which foreign bodies may reach the windpipe; occasionally they enter the tube from without, either by penetrating the skin and muscles of the neck, as in the remarkable instance observed by De La Martinière, in which a little boy, in cracking a whip, forced a brass pin into the windpipe; or they may be pushed into the passage from the œsophagus, in consequence of the attempts made to extract them from this canal, as in a case which occurred to Dr. Eve. Again, foreign bodies may enter the lungs through the walls of the chest, instead of passing into them by the more natural and common route of the glottis. Finally, a case has been recorded by Mr. Edwards, of England, in which a bronchial lymphatic gland, an inch in length, passed

through an ulcer in one of the bronchial tubes, and suffocated the patient, a boy eight years of age, by becoming impacted in the rima of the glottis.

Expansion.—When the foreign body is of a vegetable or an animal nature, it is liable to imbibe some of the moisture of the surface with which it lies in contact, and thus increase in volume. The heat of the part, no doubt, also contributes to this result. The degree of expansion produced under the joint influence of these causes varies too much to admit of precise statement. Beans, peas, and grains of corn, seem to be particularly prone to increase in bulk; sometimes a great deal even in a very short time. Occasionally the substance exhibits signs of germination. On the other hand, there are certain bodies which are incapable of thus expanding, as melon, orange, pear, and similar seeds, and bits of beef, cartilage, tendon, apple, cabbage, turnip, and other vegetable matter.

It is probable that the particular situation of the foreign body has some influence upon the change of bulk and consistence wrought upon it during its sojourn in the windpipe. A substance impacted in one of the bronchial tubes would, it is presumable, be likely to experience this change in a greater degree, as well as more rapidly, than one lodged in the trachea, or larynx. The extent of contact should also be taken into account; and, finally, the character and quantity of the secretion excited by the presence of the extraneous body. A case has been related by Professor Alonzo Buck, in which a dime, lodged for four years in the right bronchial tube, had been converted into the sulphuret of silver, and was coughed up in three pieces as black as charcoal.

When a foreign body is long retained, especially in one of the bronchial tubes, it not unfrequently becomes incrustated with various kinds of matter, as inspissated mucus, mucus and lymph, lymph alone, or carbonate and phosphate of lime.

Pathological Effects.—The foreign substance may produce various changes in the structures with which it lies in contact, as well as in those in its neighborhood. Occasionally, although rarely, remote parts, as the lungs, trachea, and larynx, become affected, either primarily or secondarily, in consequence of the irritation thus induced.

Inflammation of the mucous membrane, generally, however, of limited extent, is a very common occurrence. When the foreign body is bulky, and creates great inconvenience, or is retained for a long time, the morbid action is diffused, often spreading a considerable distance beyond the part originally affected, and leading to deposits of lymph, if not also to softening. In chronic cases, the mucous membrane is liable to become thickened, indurated, deeply congested, or even ulcerated. Sometimes the foreign body is partially surrounded by lymph, which thus serves to fix it in its situation.

When the extraneous substance is retained in the bronchial tubes, serious disease is liable to occur in the lungs, especially inflammation, which sometimes involves an entire lobe, if not the whole of the corresponding organ; now and then, indeed, the mischief extends even to the other lung, or both viscera may suffer simultaneously. Occasionally abscesses form, and continue to discharge for an indefinite period; they generally occur at the seat of the obstruction, or in its immediate vicinity, but sometimes at remote points. Their contents are of an unhealthy character, being more or less fetid, tinged with blood, and intermixed with mucus. The pulmonary tissues around them are usually densely hepatized and deeply discolored.

A remarkable instance in which a foreign body—the hull of a bean—excited gangrene of the lung, fell under my observation in 1844, in a lad ten years of age, a patient of Dr. Bryan and Dr. Rodman. The disease came on about two months and a half after the accident, and was followed by the discharge of a large quantity of thick, blackish pus, of the most fetid character. Hectic fever, with rigors and night sweats, was present, and the body was reduced to a mere skeleton. After progressing in this manner for a number of weeks, the substance was finally ejected in a violent paroxysm of coughing, ultimately succeeded by complete recovery. Fetid matter continued to be expectorated for a long time after, and the chest, over the left lung, became permanently contracted.

Sometimes, again, the foreign substance, especially if retained for any length of time, induces a deposit of tubercular matter in the tissues immediately adjoining it, as in the case of a patient of mine, nine years of age. Pulmonary emphysema is another effect, but also a very rare one; and the same remark is true of œdema of the larynx. The bronchial lymphatic glands are also liable to suffer, the most com-

mon alterations being enlargement, preternatural vascularity, and softening of their substance. Suppuration is infrequent. The morbid action sometimes extends to the pleura, leading to effusion of serum and lymph, extensive adhesions, and, also, occasionally, to the formation of pus. It is a singular fact that all these pathological changes may occur, to a greater or less extent, in cases where the obstruction is exclusively seated in the larynx, or in the upper portion of the trachea. In a few instances, the heart and pericardium have been found inflamed, but whether from an extension of the morbid action from the respiratory organs, or from embarrassment in the pulmonary and cardiac circulation, has not been determined.

When abscesses form, after this accident, whether as a consequence of simple pneumonia or of the softening of tubercular deposits, the matter generally passes into the bronchial tubes, whence it is afterwards discharged by coughing or expectoration. Occasionally it points externally at one of the intercostal spaces, where it sometimes forms an opening through which the foreign body ultimately escapes. Dr. John L. Atlee has communicated to me the particulars of a case in which he ruptured a large abscess in the lung in an attempt at extracting the foreign body. When the substance is long retained, it may excite ulceration of the bronchial tube, and finally drop into the pleural cavity, causing destructive inflammation. A case has been recorded by Mr. J. F. West, of Birmingham, in which a needle upwards of two inches and a half in length, lodged in the right bronchial tube, caused death by piercing the right ventricle of the heart.

Finally, a foreign body may provoke fatal hemorrhage, as in a case related by Rokitsansky, in which a small dart had been sucked into the trachea, and was forced into the innominate artery during a paroxysm of coughing. Dr. A. R. Terry, of Detroit, has communicated to me an instance in which frequent attacks of copious hemorrhage were excited by a gun cap, which was spontaneously expelled at the end of three years.

Symptoms.—The symptoms following and accompanying this accident may be divided into primary and secondary, or into those which take place at the moment of the introduction of the foreign body, and those which arise as a consequence of its sojourn in the air passages.

The moment a foreign substance, however small, touches the windpipe, it excites severe distress and coughing, on account of the spasmodic action which it induces in the muscles of the larynx. A familiar illustration of this occurrence is afforded in the suffering which takes place when a drop of water, a crumb of bread, or a particle of salt accidentally slips into the glottis. Instantly the most violent distress is excited, which generally continues until the intruder is dislodged. These symptoms, however, are commonly slight and transient compared with those that attend the intromission of a foreign body, properly so called. In the latter case, the patient is usually in imminent danger of suffocation, and, consequently, very fortunate if he escapes with his life. In the great majority of instances, he is seized with a feeling of annihilation; he gasps for breath, looks wildly around, coughs violently, and, perhaps, loses his consciousness. His countenance is livid, the eyes protrude from their sockets, the heart beats tumultuously, the body is contorted in every possible manner, and froth, or froth and blood, issue from the mouth and nose. Now and then he grasps his throat, utters the most distressing cries, or falls down in a state of insensibility. Sometimes he vomits, especially if the accident occurs after a full meal; and the relief occasionally experienced from this source is very great. In some instances, again, there is an involuntary discharge of feces, and even of urine. A considerable quantity of pure blood is now and then thrown up during the violent coughing, immediately consequent upon the accident.

The duration of the first paroxysm varies from a few seconds to several minutes, or, in severe cases, as when the foreign body is arrested in the larynx, even several hours. With the restoration of the respiration, the features resume their natural appearance, and the patient recovers his consciousness and power of speech. The voice, however, frequently remains somewhat altered, the breathing is more or less embarrassed, and there are frequent fits of coughing, often attended with a recurrence of all, or nearly all, the original symptoms. Thus the case may progress for an indefinite period, until the foreign body is expelled, or until it produces death by disease of the air-passages.

Should the obstruction continue, even if only for a few days, the patient will be in twofold danger; for he will not only be liable to be suffocated at any moment by the

foreign body passing up into the larynx, during a paroxysm of coughing, but the probability is that the lungs, resenting its presence, will take on inflammation, which no skill, however well directed, can always effectually arrest.

Occasionally there is almost an entire absence of symptoms, the foreign body causing little or no inconvenience. Thus, in a case reported by Louis, the patient, after the first few minutes, experienced no bad symptoms for an entire year. At the end of that time, he coughed up a cherry-stone, followed by such copious expectoration as to destroy him in three days.

The cough is usually spasmodic, sudden, short, and uncontrollable, lasting from a few seconds to half an hour or more. During its continuance, the patient frequently experiences a sense of tickling in the throat, with soreness and pain in the respiratory tubes and at the top of the sternum; the countenance is suffused, and even livid; the brain is oppressed by sanguineous determination; and, when the paroxysms are violent and protracted, there is occasionally a discharge of blood from the nose and mouth. Sometimes the cough is of a croupy character. Posture often exercises a marked influence over it. Thus, the patient may be perfectly free while sitting up, or lying down, but the moment he rises, or moves his body, he may be seized with a severe fit.

The voice is variously affected. Generally it is natural, or so nearly natural as to render it difficult, if not impossible, to detect the change. Occasionally, however, it is remarkably altered, both in quality and strength. Thus, it may be croupy, hoarse and low, sharp and sibilant, or as if cracked, reduced to a mere whisper, or entirely extinct. These alterations may occur immediately after the accident, or not until the foreign body has set up irritation in the vocal cords. Sometimes the power of speech is temporarily lost, and then returns, either suddenly or gradually, without any assignable cause.

The expectoration is ordinarily small, and of a thin, sero-mucous character. In protracted cases, however, and especially when there is a good deal of bronchial irritation, it may be very copious, thick, and ropy, more or less opaque, of a dirty, rust-colored aspect, or tinged with blood. When cavities form around the foreign body, whether from gangrene, or from the softening of tubercular matter, the expectoration is generally almost insupportably offensive.

Sometimes the patient throws up blood, either pure or mixed with frothy matter. The quantity is usually very small, not exceeding a few drachms. The accident may occur immediately after the introduction of the foreign substance, or not until serious structural changes have taken place in the lungs.

The pain which follows this accident is generally very slight, except when the resulting inflammation has produced serious structural lesion. In its character, it may be sharp and pricking, or dull, heavy, and aching; it may be limited to the seat of the foreign body, or it may pervade the trachea, larynx, bronchial tubes, and lungs, if not also the throat, œsophagus, and muscles of the chest. It is commonly accompanied by a sense of constriction, tightness, or suffocation, and is liable to be aggravated by coughing and the slightest change in the situation of the foreign body. It is occasionally fixed for a long time at one spot, and then suddenly shifts to another. Sometimes, again, it remains at its original site for a considerable period after the extrusion of the foreign substance.

Instead of pain, there may merely be a feeling of soreness. This may occur at various points of the respiratory apparatus, and is, perhaps, more frequently present than is commonly imagined, owing to the want of a thorough examination, or the fact that the patient is not always able to indicate the nature of his sufferings.

No substance can remain for any length of time in the air-passages without causing more or less serious disturbance in the respiratory functions. The patient has hardly escaped from the immediate effects of the accident before his life is endangered by inflammation, which, if not promptly relieved, may speedily prove fatal. This effect, which is always to be dreaded in every case of the kind, devolves upon the attendant the absolute necessity of frequent examinations of the chest, both by auscultation and percussion.

One of the most remarkable circumstances after this accident is that, while the patient can freely inspire, he often finds it almost impossible to expire. This is particularly the case when the foreign body lies in one of the bronchial tubes, which may thus be almost completely closed, neither allowing the air to enter nor

to pass out. Nevertheless, as the other canal remains free, inspiration may be carried on with considerable vigor, whereas every attempt to expel the air from the obstructed lung will be attended with great suffering and a feeling of exhaustion. If, under such circumstances, the ear be applied to the chest, the respiratory murmur on the affected side will be found to be either entirely inaudible, or but faintly appreciable, while on the sound side it will either be perfectly natural, more or less puerile, or characterized by various râles. Whenever this happens, the thorax will be found to be everywhere perfectly clear on percussion; the reverse being, of course, the case when there is hepatization from disease, or excessive engorgement of the pulmonary tissues, as will necessarily occur, in nearly every instance, within a short time after the foreign body has reached the air-passages. Occasionally, the air, as it rushes by the foreign body, produces sounds so peculiar that they may be regarded as pathognomonic of the nature of the affection. Thus, in a case observed by Mr. McNamara, of Dublin, the noise resembled that produced by blowing through a whistle, the foreign substance, a plum-stone, being perforated at the middle. Occasionally, the substance, as it plays up and down the windpipe, produces a peculiar flapping sound. Finally, the symptoms may be of an asthmatic character.

The posture of the patient varies. Generally he finds it most agreeable to sit up; for as soon as he attempts to lie down he is seized with increased embarrassment of breathing, with a disposition to cough and a feeling of suffocation: during sleep he is, consequently, obliged to be propped up in bed, or to rest in a chair. Sometimes, however, he lies best on his back, or on one side.

The general health is variously affected; sometimes lightly, sometimes severely, sometimes, again, not at all. In most cases, however, even when the foreign substance is not retained beyond a few days, the system is feverish, the appetite and sleep are interrupted, and there is an anxious expression of the features. If the irritation continues, inflammation of the lungs and air-tubes soon takes place, with an aggravation of the cough, emaciation, and loss of strength.

Diagnosis.—As these accidents occur most frequently in infants and children, who can but ill express their feelings, one of the first duties of the practitioner is to inquire, most carefully and circumstantially, into the history of the case. Very frequently some time elapses before he can reach the patient, or it may be that, although the interval between the occurrence and his visit may be very short, the first symptoms may have entirely disappeared, and the patient act and feel as if nothing had taken place. Now, it is just in such cases as these that errors are most liable to happen, for the reason that the professional attendant, seeing that there is apparently nothing the matter, allows his mind to be lulled into a state of security, frequently not less injurious to himself than destructive to his patient. It is different with adults, who are usually conscious of the time and manner of such accidents, and who, therefore, rarely fail to give a correct account of them.

If the patient, supposing him to be a child, has been playing with a grain of corn, bean, pebble, or similar body, and has been suddenly seized with symptoms of suffocation, violent spasmodic cough, lividity of the face, pain in the upper part of the windpipe, and partial insensibility, there will be a strong presumption that the substance, whatever it may have been, has slipped into the air-passages, and is the immediate and only cause of the suffering. The presumption will be converted almost into positive certainty if the child was just previously in the enjoyment of good health; if he was romping, jumping, or laughing at the moment of the accident, with the substance, perhaps, in his mouth, or while attempting to throw it into that cavity; and especially, if the symptoms, after having been interrupted for a few minutes, continue to recur, with their former, or even with increased, intensity, at longer or shorter intervals. The symptoms here enumerated, however, are sometimes most painfully simulated by the cough and embarrassment of breathing occasioned by cold and other affections. The difficulty in arriving at a correct diagnosis is still further augmented, in some of these cases, by the coincidence of the respiratory trouble and the fact of the child, at the moment of the seizure, having been engaged in playing with a substance such as that above mentioned.

Important information may frequently be obtained by auscultation and percussion, particularly when the foreign body is situated in the lower extremity of the trachea,

time, the tube above the opening is very apt to become contracted, thus interfering materially with the cure of the case.

The treatment consists in paring the edges of the opening, both in the tube and in the integument, and in approximating them by several points of the interrupted suture. The milder cases occasionally yield to gentle cauterization with the nitrate of silver.

XIII.—INCURVATION OF THE EPIGLOTTIS.

In this affection, the free margin of the epiglottis is curled backwards in the form of a scroll, which, by encroaching upon the mouth of the larynx, keeps up constant irritation and tickling cough, with a disposition to clear the throat of mucus, hoarseness, partial aphonia, and paroxysms of suffocation. It presents itself in various degrees, is usually caused by ulceration, either simple or specific, is most common in middle-aged and elderly persons, and is frequently associated with chronic inflammation of the larynx, tonsils, and fauces. The diagnosis is readily determined by the finger and the laryngoscope. In a case recently under my charge, in a woman 45 years old, the suffering was most distressing, although the disease had existed for about four months. The general health was much impaired from the loss of sleep, consequent upon the violent and incessant cough and the constant discharge from the throat of mucus, which was secreted in large quantities.

The proper remedy for this complaint is cauterization of the laryngeal surface of the epiglottis with nitrate of silver, or, what I prefer, a weak solution of acid of mercury, repeated every fourth or fifth day. The general health should be amended; and, if there is reason to suspect a syphilitic taint of the system, recourse should be had to some of the iodides in union with bichloride of mercury. If the incurvation cannot be thus relieved, and the case assumes a threatening character, the offending portion of the epiglottis should be sliced off with the bistoury and probe-pointed bistoury, although such a procedure will rarely be necessary.

The epiglottis is occasionally remarkably shrivelled and contracted, or singularly attenuated and elongated, its form being altered in such a manner as to resemble the outline of a battledoor, the narrow extremity being at the mouth of the larynx. The lesion usually coexists with ulceration, and is most frequently met with in phthisical and syphilitic subjects. Sometimes the epiglottis is congenitally cleft in the centre, so as to give it a bifid appearance, a condition analogous to hare-lip or fissure of the palate, with which it is generally associated.

XIV.—HERNIA OF THE TRACHEA.

The trachea is liable to protrusion of its lining membrane between two rings, constituting what has been, absurdly enough, called "bronchial hernia." It is usually caused by severe straining; either suddenly, as occasionally happens in violent labor from forcibly holding the breath, or gradually, in consequence of long and habitual efforts with the voice. The tumor which is thus formed is remarkable for its softness, and varies from the size of a pea to that of a pigeon's egg, increasing during exertion and diminishing under pressure. It produces no permanent inconvenience, except what results from the disfigurement which it occasions. The proper remedy is steady, systematic compression, which, if it do not produce a permanent cure, will, at all events, have the effect of preventing further increase of the affection.

XV.—INJURIES.

a. *Wounds.*—Wounds of the windpipe, although in themselves not particularly dangerous, nearly always become so, on account of the entrance of blood, the threatening suffocation, and of the remarkable susceptibility of the lungs, after such lesions, to inflammation. Edema of the glottis is also liable to supervene, especially when the injury is situated high up in the larynx. Another effect that not infrequently follows such accidents is a loss of sensibility of the glottis, in consequence of which, as stated by Mr. Erichsen, who has paid particular attention to the subject, it no longer contracts on the application of ordinary stimulants, as food and drink, but permits them to pass into the larynx, thereby inducing violent cough and serious respiratory difficulty, even although the pharynx and œsophagus retain their

grit y. These, then, are the great sources of peril in cases of this description, and, therefore, too much vigilance cannot be exercised in guarding against their occurrence. When the tube is completely divided, the danger is, of course, imminent, death usually following in a short time from suffocation from the ingress of blood. In a case communicated to me by Dr. James D. Maxwell, of Indiana, a child, twelve years of age, lived fifteen days in this condition. The windpipe had been completely severed between the cricoid and thyroid cartilages. The œsophagus had also been freely divided. The immediate cause of death was broncho-pneumonic inflammation. Separation of the epiglottis is also generally fatal; if the detachment is partial, the flap may become entangled in the glottis; if complete, death will be likely to happen from inanition or inflammation. Larrey and others, however, have mentioned cases in which the epiglottis was shot completely away, and yet the patients made a good recovery.

A wound of the thyroid cartilage, penetrating the larynx, is generally a serious accident, as it may be complicated with copious hemorrhage into the windpipe, or be followed by violent inflammation. The danger of such a lesion will be particularly great if, as sometimes happens, the opening extends into the vocal cords, as œdema of the glottis will then be almost sure to arise, and occasion fatal suffocation.

The arytenoid cartilages are sometimes implicated, as in the interesting case recorded by Sir Charles Bell. A man, who had cut his throat, suffered from repeated attacks of frightful dyspœa, accompanied with a peculiar flapping sound in the top of the windpipe, for which no rational explanation could be offered. He finally died in a fit of suffocation, when it was ascertained that one of the arytenoid cartilages had been divided, the fragment hanging by a piece of mucous membrane, so as to vibrate in the chink of the glottis, like a pea in a cateall.

Gunshot wounds of the windpipe are generally mortal, although occasionally recovery takes place under circumstances apparently of the most desperate character. There is reason to believe that this tube possesses the faculty of deflecting bullets. Thus, in a case which I attended with Dr. Hooper, a man was struck by a pistol ball directly over the middle line of the neck, about two inches above the sternum, and yet there was no symptom whatever denotive of perforation of the trachea, or of serious lesion of any kind.

The treatment of wounds of the windpipe should be conducted by suture and position, along with strict surveillance over the lungs. Although surgeons generally are averse to the employment of the suture for such a purpose, I cannot share their fears in regard to its alleged injurious effects. It is the abuse, and not the proper use, of the remedy that does the mischief. The treatment in wounds of the larynx and trachea is always perfectly safe if approximation be postponed until all danger of internal bleeding has ceased, as it usually will in five or six hours. The needle, a very delicate one, armed with silver wire, should be passed simply through the fibrous covering of the trachea, without, of course, including any portion of its rings. The external wound is closed in the usual manner. If any of the cervical muscles are divided, their extremities should be tacked together with the needle and thread. When the larynx is opened, the sutures are carried through the perichondrium, or even through the edges of the cartilages themselves. When the epiglottis is nearly severed, the best plan will be to cut off the flap, lest, falling into the glottis, it should cause suffocation. The dressing is completed by placing the head in an easy, comfortable position, with a slight inclination forwards, and confining it there by means of a tightly fitting head-bandage, the extremities of which are secured to a broad roller encircling the upper part of the chest. The head must not be drawn too far forwards, otherwise the edges of the wound, both in the windpipe and in the soft parts, may overlap.

In a case, recently communicated to me by Dr. W. R. Van Hook, of Illinois, in which the larynx was completely severed by a razor between the cricoid and thyroid cartilages, along with a portion of the œsophagus, the parts thus treated united perfectly in less than one month. No sutures were inserted into the œsophagus. The head was confined to the chin, and cough allayed by morphia.

The advantages of the suture in wounds of the windpipe are, first, a more rapid cure, and, consequently, less danger of hemorrhage and inflammation; secondly, greater facility of administering food and drink; and, lastly, much less risk of the occurrence of stricture and fistule. Should emphysema or internal bleeding arise after the parts have been approximated, it would be easy to open the wound, to a

small extent in front, both in the integument and in the windpipe, and even to introduce a canula, until all danger from these causes has subsided.

The after-treatment is strictly antiphlogistic. The tongue is frequently moistened with iced water; food and drink are, if necessary, conveyed into the stomach by means of a suitable tube, passed through the mouth; and the bowels are moved by enemata. In very bad cases, involving serious lesion of the pharynx or œsophagus, life must be sustained by beef essence, brandy, and other means, introduced by the rectum. Cough is allayed, and sleep induced, by morphia. The head and shoulders are elevated, and the dressings are disturbed as little as possible, the sutures being retained as long as they may seem to do good. Pulmonic and bronchial involvement are met by the usual means. The temperature of the patient's apartment is regulated by the thermometer, and constantly kept at 80° of Fahrenheit. The admission of cold air, especially through the wound, cannot fail to be pernicious, from its tendency to awaken cough and inflammation of the respiratory organs. The patient must be watched with the greatest possible assiduity. If he is suicidally inclined, he must be put in the straight jacket, otherwise he will be sure to tear away the dressings, and open the wound, if he do not inflict other mischief.

Danger may arise during the treatment of laryngeal wounds, from the formation of exuberant granulations, which, extending into the interior of the tube, may so encroach upon it as to cause excessive dyspnoea, if not fatal obstruction. The proper remedy is the removal of the redundant material with the scissors, and afterwards effectually cauterizing the raw surfaces with nitrate of silver. If this treatment fail, recourse must be had to tracheotomy, the incision being kept open until thorough cicatrization is effected.

β. Laceration.—Laceration of the windpipe is occasionally met with, generally as the result of a blow, kick, or fall upon the neck, without any external wound, and is always a dangerous accident, imperilling life by paralysis of the air-passages, spasm of the glottis, or suffocation from emphysema. Of 13 cases, collected by Dr. Fischer, of Hannover, in 7 of which the trachea alone was involved, only 2 recovered, the tube having been opened in one. The remaining 6, which were complicated with fracture of the laryngeal cartilages or the hyoid bone, perished. In a case observed by Dr. John L. Atlee, the patient, a boy, aged four years, perished from emphysema in less than fifteen minutes after the receipt of the injury, produced by striking his neck forcibly against a door-scraper. The air, under such circumstances, escapes from the wounded parts into the cellular tissue of the cervical region, from which it spreads more or less rapidly over the head, trunk, and even the upper extremities, followed by frightful dyspnoea, and, if succor is not promptly afforded, by death.

These injuries may affect both the larynx and the trachea, the former apparently more frequently than the latter. Laceration of the trachea alone may be caused by a sudden and violent effort at inspiration after the integrity of the tube has been impaired by atrophy and ulceration, as in an instance reported to me by Dr. Thomas Marshall, of Kentucky. Coughing has been known to produce a similar accident, a case having been recorded by Bredschneider in a child, twenty-one months of age, affected with bronchitis. The occurrence was denoted by emphysema of the neck and chest, and the tube was found to be ruptured to the extent of six lines below the first ring.

The proper remedy in these injuries is obviously tracheotomy, performed without a moment's delay, especially if there is a rapid escape of air into the surrounding structures. In fact, in case of extreme urgency, the operation should be attempted even if the patient is in the act of dying, or has actually ceased to breathe. The wound should be kept open with a suitable tube, the head maintained in a fixed position, and every effort made to allay spasm and prevent the occurrence of severe inflammation. The skin must be freely punctured, if there is extensive emphysema.

Tracheotomy is not a new operation in this class of injuries. Habicot performed it successfully, in 1594, upon a man whose thyroid cartilage had been struck by a bullet, causing such an amount of dyspnoea as to threaten suffocation. Liston resorted to it in 1823, and since that time it has occasionally been employed by others.

γ. Contusion.—Contusion of the windpipe, especially of the larynx, is sometimes followed by very unpleasant symptoms. Such an accident, in fact, may prove suddenly fatal from closure of the rima of the glottis, in consequence of spasm of the

laryngeal muscles. The exciting cause is generally a blow or fall upon the neck; and the proper remedy, in case of urgency, is laryngotomy, performed without a moment's delay, a tube being retained in the wound until thorough relief is obtained. When the symptoms are less severe, the chief reliance should be upon antiphlogistics, as leeches, blisters, purgatives, and tartar emetic in union with morphia. If the patient remains aphonic for a long time, recourse should be had to mercury, in alterative and frequently-repeated doses, with stimulating embrocations to the neck.

5. *Fracture of the Larynx.*—The cartilages of the larynx may be broken by external violence, as a fall or a blow, the kick of a horse, or the pressure of the thumb and fingers. The accident is most common in elderly subjects, after partial ossification of these bodies, and the one which is most liable to suffer is the thyroid. Of 27 cases analyzed by Dr. William Hunt, of this city, including one observed by himself, only 5 were in children. The fracture may be simple, comminuted, or complicated. The only reliable diagnostic symptoms are crepitation, displacement of the fragments, and preternatural mobility. The ordinary accompaniments are difficulty of articulation, breathing, and deglutition, loss of voice, cough, hemorrhage, and emphysema, from an escape of air into the surrounding cellular tissue. The discrimination may be rendered very difficult, if not impracticable, by great tumefaction of the neck.

Most of the cases of this accident prove fatal either soon after its occurrence from suffocation, or more or less remotely from the effects of inflammation. Of the 27 cases analyzed by Dr. Hunt, 17 died. In 8 laryngotomy was performed, with 2 deaths, and 6 recoveries. More extended observations show even a greater mortality. Thus, of 62 cases collected by Hénoque and Durham, 50 died, and 12 got well, tracheotomy having been performed in eight. In every instance, 21 in number, in which the cricoid cartilage was fractured, the result was fatal.

Fracture of the laryngeal cartilages, unless attended with serious displacement, requires little else than the ordinary antiphlogistic measures, with perfect quietude of the head, neck, and tongue. When the symptoms are urgent, threatening suffocation, the proper remedy is tracheotomy performed with the least possible delay. The larynx may be opened when there is extensive separation of the fragments, as such a procedure would afford greater facilities for effecting replacement; but ordinarily tracheotomy deserves the preference. If the orifice is sufficiently large, there will be no need of a tube. In a case, reported in 1866, by Professor Maclean, of Kingston, Canada, tracheotomy was rendered necessary, and was successfully performed, on account of œdema of the glottis consequent upon a comminuted fracture of the thyroid cartilage, attended with excessive apnœa, dysphagia, and emphysema of the neck.

1. *Scalds of the Larynx.*—Scalds of the larynx may be caused by the inhalation of steam or the contact of hot fluids, the subjects of the accident being usually very young children. Intense pain, restlessness, and difficulty of swallowing, followed by impeded respiration dependent upon œdema of the glottis, and broncho-pulmonary congestion are the characteristic symptoms of the occurrence. The mouth, tongue, and fauces are red, as well as here and there vesicated, and evidences of the effects of hot fluid also frequently exist upon the cheeks. The epiglottis is hard, round, and contracted, as if it had been scorched. In the worst forms of the accident, the voice is croupy, sonorous râles are heard over the chest, the countenance is of a purplish hue, the pulse is rapid and feeble, the surface is cold and damp, the eyes are rolled up, the pupils are dilated, and the patient is semicomatose. If prompt relief be not obtained, death ensues from spasm of the larynx, or from the joint influence of spasm and inflammation, the latter often extending to the bronchial tubes and to the substance of the lungs.

The kind of treatment must depend upon the violence and extent of the injury. The milder cases will generally readily yield to ordinary antiphlogistic measures, as an active purgative, a gentle emetic to expel the redundant mucous secretion, and leeches to the neck, or the upper part of the sternum. When the symptoms are urgent, tracheotomy should be performed, as it is frequently the only chance of prolonging or saving life, although the result is generally unfavorable, as is shown by the statistics of Mr. Durham, in which, out of 28 cases, only 5 recovered.

Professor Bevan, of Dublin, has met with four cases of scalds of the larynx all

successfully treated by emetics, leeches to the upper part of the sternum, and calomel, in doses of one to two grains every half hour, until free bilious evacuations were produced.

XVI.—FOREIGN BODIES.

The air-passages are liable to the intrusion of a great variety of substances, referable to four distinct classes, vegetable, animal, mineral, and mixed, the latter comprising such as are partly vegetable and partly animal, partly animal and partly mineral, or partly mineral and partly vegetable. Of these different substances, those which most commonly enter the air-passages, at least in this country, are grains of corn, beans, melon-seeds, pebbles, and cherry-stones. Bits of meat, bone, and gristle are also frequent intruders. Pieces of coin, pins, buttons, and similar articles are extremely liable to be entrapped in the windpipe, in consequence, apparently, of the foolish habit, so common everywhere, of holding such substances heedlessly in the mouth. I am acquainted with a number of cases, one of which fell under my own observation, in which the foreign body was a cockle-bur, represented in fig. 297. Substances of extraordinary size sometimes pass into the air-tubes. Thus, in the case of a child between three and four years of age, communicated to me by Dr. Foote, of Indiana, the foreign body, a brass pen-holder, was

Fig. 297.



Cockle-bur.

Fig. 298.



Ear of Grass.

three inches and a half in length by three lines in diameter. It had descended into the left bronchial tube, where it was found after death, nine months after the accident, surrounded by thick matter. Several instances have been reported of the accidental inhalation of the ears of rye, wheat, barley, and grass, as in fig. 298. Dr. J. C. Reeve, of Ohio, in 1869, extracted by tracheotomy, from a little girl, a shawl-pin, fig. 299, upwards of three inches in length. Worms, especially the lum-

Fig. 299.



bricoid variety, have been known to creep into the windpipe; and at least one man has lost his life from the introduction of a leech into the sinus of the larynx. Gautier has reported a case of death from the inhalation of a small fish.

In my Treatise on Foreign Bodies in the Air-Passages, published in 1854, a number of cases are mentioned in which teeth, both natural and artificial, were inhaled. In several of the cases, the artificial teeth were connected together by metal, as in fig. 300. In this instance, the substance was retained for thirteen years, and was found, on dissection, in the right thoracic cavity, into which it had passed by ulceration. Mr. Nunn attended a man who drew a puff-dart, represented in fig. 301, into his windpipe. Occasionally, the entrapped substance has been a bullet, as in two instances, reported to me, respectively, by Dr. Maxwell, of Indiana, and by Dr. Stitt, of Kentucky. A case occurred in this city, in 1867, in which a man, twenty-three years of age, lost his life from the inhalation of a cork during the extraction of a molar tooth while under the influence of nitrous oxide gas. The cork had been placed between the jaws, and was found by Dr. Shapleigh after death, which hap-

pened within less than two hours after the accident, in the lower extremity of the trachea. The specimen is in my cabinet. Dr. Underhill has reported a case in which the foreign body consisted of the copper tip of an umbrella; and Dr. G. Buck one of a hard rubber tube, upwards of two inches and a half in length by six lines in diameter.

Fig. 300.



Artificial Teeth.

Fig. 301.



Puff-dart.

Two, three, and even four foreign substances sometimes enter the air-tubes, either simultaneously or successively. Dr. Sipe, of Missouri, has communicated to me the particulars of the case of a child, who, when the larynx was opened, ejected not less than a dozen fragments of parched corn.* Dr. Mount, of Cincinnati, met with an instance, in an infant five weeks old, who, after the operation of laryngo-tracheotomy, expelled four pieces of unburnt coffee, three immediately, and the other and largest one the next day. Sometimes the substances are of a dissimilar character. Thus, in a case observed by Professor Van Buren, the child, upon the windpipe being opened, coughed up a water-melon seed and the shank of a plum.

Situation.—The foreign body may be arrested in different portions of the windpipe, or it may remain loose, and move up and down the canal during the expulsion and introduction of the air. Occasionally, it is stopped at the very entrance of the larynx; but more frequently, by far, it passes into the interior of the tube, and lodges in one of its ventricles. It is not often arrested in the trachea, or, if arrested, it does not long remain there. Instead of this, after having passed the larynx, it generally, either at once or at a very early period, descends into one of the bronchial tubes, from which, however, during a violent expiratory effort, it may again be impelled upwards, not only into the trachea, but even into the larynx. A needle, pin, bit of bone, or, in short, any sharp and slender body, might be permanently retained in the trachea, in consequence of its extremities becoming implanted in its walls; so also might a cockle-bur, a piece of meat, a lump of cheese, or a piece of sponge. A solid or a heavy body, as a bullet, pebble, shot, or grain of corn, will, on the contrary, be almost certain to pass at once into the bronchial tubes, in obedience simply to the laws of gravity. A case in which seven artificial teeth, set in gutta-percha, were arrested at the junction of the larynx and trachea, has been recorded by Mr. Henry G. Croly, of Dublin.

When a foreign body passes into the bronchial tubes, its tendency is to lodge in the right; a circumstance which has long been known, and variously explained. Thus, it has been supposed to be owing to the differences in the capacity and direction of the two tubes, the right being larger than the left and placed more horizontally. The real cause, however, would seem to be the ridge, or spur, in the lower part of the trachea, the position of which, towards the left of the mesial plane, has the effect of throwing the foreign body, as it descends, over towards the right side, an effect still further favored by the greater diameter of the passage. Sometimes, each bronchial tube contains a foreign body; and occasionally, again, although rarely, the substance is forced on beyond the primitive division into a secondary one.

The glottis, although by far the most common, is not the only avenue by which foreign bodies may reach the windpipe; occasionally they enter the tube from without, either by penetrating the skin and muscles of the neck, as in the remarkable instance observed by De La Martinière, in which a little boy, in cracking a whip, forced a brass pin into the windpipe; or they may be pushed into the passage from the œsophagus, in consequence of the attempts made to extract them from this canal, as in a case which occurred to Dr. Eve. Again, foreign bodies may enter the lungs through the walls of the chest, instead of passing into them by the more natural and common route of the glottis. Finally, a case has been recorded by Mr. Edwards, of England, in which a bronchial lymphatic gland, an inch in length, passed

through an ulcer in one of the bronchial tubes, and suffocated the patient, a boy eight years of age, by becoming impacted in the rima of the glottis.

Expansion.—When the foreign body is of a vegetable or an animal nature, it is liable to imbibe some of the moisture of the surface with which it lies in contact, and thus increase in volume. The heat of the part, no doubt, also contributes to this result. The degree of expansion produced under the joint influence of these causes varies too much to admit of precise statement. Beans, peas, and grains of corn, seem to be particularly prone to increase in bulk; sometimes a great deal even in a very short time. Occasionally the substance exhibits signs of germination. On the other hand, there are certain bodies which are incapable of thus expanding, as melon, orange, pear, and similar seeds, and bits of beef, cartilage, tendon, apple, cabbage, turnip, and other vegetable matter.

It is probable that the particular situation of the foreign body has some influence upon the change of bulk and consistence wrought upon it during its sojourn in the windpipe. A substance impacted in one of the bronchial tubes would, it is presumable, be likely to experience this change in a greater degree, as well as more rapidly than one lodged in the trachea, or larynx. The extent of contact should also be taken into account; and, finally, the character and quantity of the secretion excited by the presence of the extraneous body. A case has been related by Professor Alonzo Buck, in which a dime, lodged for four years in the right bronchial tube, had been converted into the sulphuret of silver, and was coughed up in three pieces a black as charcoal.

When a foreign body is long retained, especially in one of the bronchial tubes, it not unfrequently becomes incrustated with various kinds of matter, as inspissated mucus, mucus and lymph, lymph alone, or carbonate and phosphate of lime.

Pathological Effects.—The foreign substance may produce various changes in the structures with which it lies in contact, as well as in those in its neighborhood. Occasionally, although rarely, remote parts, as the lungs, trachea, and larynx become affected, either primarily or secondarily, in consequence of the irritation thus induced.

Inflammation of the mucous membrane, generally, however, of limited extent, is a very common occurrence. When the foreign body is bulky, and creates great inconvenience, or is retained for a long time, the morbid action is diffused, often spreading a considerable distance beyond the part originally affected, and leading to deposits of lymph, if not also to softening. In chronic cases, the mucous membrane is liable to become thickened, indurated, deeply congested, or even ulcerated. Sometimes the foreign body is partially surrounded by lymph, which thus serves to fix it in its situation.

When the extraneous substance is retained in the bronchial tubes, serious disease is liable to occur in the lungs, especially inflammation, which sometimes involves an entire lobe, if not the whole of the corresponding organ; now and then, indeed, the mischief extends even to the other lung, or both viscera may suffer simultaneously. Occasionally abscesses form, and continue to discharge for an indefinite period; they generally occur at the seat of the obstruction, or in its immediate vicinity, but sometimes at remote points. Their contents are of an unhealthy character, being more or less fetid, tinged with blood, and intermixed with mucus. The pulmonary tissue around them are usually densely hepatized and deeply discolored.

A remarkable instance in which a foreign body—the hull of a bean—excited gangrene of the lung, fell under my observation in 1844, in a lad ten years of age, a patient of Dr. Bryan and Dr. Rodman. The disease came on about two months and a half after the accident, and was followed by the discharge of a large quantity of thick, blackish pus, of the most fetid character. Hectic fever, with rigors and night sweats, was present, and the body was reduced to a mere skeleton. After progressing in this manner for a number of weeks, the substance was finally ejected in a violent paroxysm of coughing, ultimately succeeded by complete recovery. Fetid matter continued to be expectorated for a long time after, and the chest, over the left lung, became permanently contracted.

Sometimes, again, the foreign substance, especially if retained for any length of time, induces a deposit of tubercular matter in the tissues immediately adjoining it as in the case of a patient of mine, nine years of age. Pulmonary emphysema is another effect, but also a very rare one; and the same remark is true of oedema of the larynx. The bronchial lymphatic glands are also liable to suffer, the most com-

most alterations being enlargement, preternatural vascularity, and softening of their substance. Suppuration is infrequent. The morbid action sometimes extends to the pleura, leading to effusion of serum and lymph, extensive adhesions, and, also, occasionally, to the formation of pus. It is a singular fact that all these pathological changes may occur, to a greater or less extent, in cases where the obstruction is exclusively seated in the larynx, or in the upper portion of the trachea. In a few instances, the heart and pericardium have been found inflamed, but whether from an extension of the morbid action from the respiratory organs, or from embarrassment in the pulmonary and cardiac circulation, has not been determined.

When abscesses form, after this accident, whether as a consequence of simple pneumonia or of the softening of tubercular deposits, the matter generally passes into the bronchial tubes, whence it is afterwards discharged by coughing or expectoration. Occasionally it points externally at one of the intercostal spaces, where it sometimes forms an opening through which the foreign body ultimately escapes. Dr. John L. Atlee has communicated to me the particulars of a case in which he ruptured a large abscess in the lung in an attempt at extracting the foreign body. When the substance is long retained, it may excite ulceration of the bronchial tube, and finally drop into the pleural cavity, causing destructive inflammation. A case has been recorded by Mr. J. F. West, of Birmingham, in which a needle upwards of two inches and a half in length, lodged in the right bronchial tube, caused death by piercing the right ventricle of the heart.

Finally, a foreign body may provoke fatal hemorrhage, as in a case related by Rokitsky, in which a small dart had been sucked into the trachea, and was forced into the innominate artery during a paroxysm of coughing. Dr. A. R. Terry, of Detroit, has communicated to me an instance in which frequent attacks of copious hemorrhage were excited by a gun cap, which was spontaneously expelled at the end of three years.

Symptoms.—The symptoms following and accompanying this accident may be divided into primary and secondary, or into those which take place at the moment of the introduction of the foreign body, and those which arise as a consequence of its sojourn in the air passages.

The moment a foreign substance, however small, touches the windpipe, it excites severe distress and coughing, on account of the spasmodic action which it induces in the muscles of the larynx. A familiar illustration of this occurrence is afforded in the suffering which takes place when a drop of water, a crumb of bread, or a particle of salt accidentally slips into the glottis. Instantly the most violent distress is excited, which generally continues until the intruder is dislodged. These symptoms, however, are commonly slight and transient compared with those that attend the intromission of a foreign body, properly so called. In the latter case, the patient is usually in imminent danger of suffocation, and, consequently, very fortunate if he escapes with his life. In the great majority of instances, he is seized with a feeling of annihilation; he gasps for breath, looks wildly around, coughs violently, and, perhaps, loses his consciousness. His countenance is livid, the eyes protrude from their sockets, the heart beats tumultuously, the body is contorted in every possible manner, and froth, or froth and blood, issue from the mouth and nose. Now and then he grasps his throat, utters the most distressing cries, or falls down in a state of insensibility. Sometimes he vomits, especially if the accident occurs after a full meal; and the relief occasionally experienced from this source is very great. In some instances, again, there is an involuntary discharge of feces, and even of urine. A considerable quantity of pure blood is now and then thrown up during the violent coughing, immediately consequent upon the accident.

The duration of the first paroxysm varies from a few seconds to several minutes, or, in severe cases, as when the foreign body is arrested in the larynx, even several hours. With the restoration of the respiration, the features resume their natural appearance, and the patient recovers his consciousness and power of speech. The voice, however, frequently remains somewhat altered, the breathing is more or less embarrassed, and there are frequent fits of coughing, often attended with a recurrence of all, or nearly all, the original symptoms. Thus the case may progress for an indefinite period, until the foreign body is expelled, or until it produces death by disease of the air-passages.

Should the obstruction continue, even if only for a few days, the patient will be in twofold danger; for he will not only be liable to be suffocated at any moment by the

foreign body passing up into the larynx, during a paroxysm of coughing, but the probability is that the lungs, resenting its presence, will take on inflammation, which no skill, however well directed, can always effectually arrest.

Occasionally there is almost an entire absence of symptoms, the foreign body causing little or no inconvenience. Thus, in a case reported by Louis, the patient, after the first few minutes, experienced no bad symptoms for an entire year. At the end of that time, he coughed up a cherry-stone, followed by such copious expectoration as to destroy him in three days.

The cough is usually spasmodic, sudden, short, and uncontrollable, lasting from a few seconds to half an hour or more. During its continuance, the patient frequently experiences a sense of tickling in the throat, with soreness and pain in the respiratory tubes and at the top of the sternum; the countenance is suffused, and even livid; the brain is oppressed by sanguineous determination; and, when the paroxysms are violent and protracted, there is occasionally a discharge of blood from the nose and mouth. Sometimes the cough is of a croupy character. Posture often exercises a marked influence over it. Thus, the patient may be perfectly free while sitting up, or lying down, but the moment he rises, or moves his body, he may be seized with a severe fit.

The voice is variously affected. Generally it is natural, or so nearly natural as to render it difficult, if not impossible, to detect the change. Occasionally, however, it is remarkably altered, both in quality and strength. Thus, it may be croupy, hoarse and low, sharp and sibilant, or as if cracked, reduced to a mere whisper, or entirely extinct. These alterations may occur immediately after the accident, or not until the foreign body has set up irritation in the vocal cords. Sometimes the power of speech is temporarily lost, and then returns, either suddenly or gradually, without any assignable cause.

The expectoration is ordinarily small, and of a thin, sero-mucous character. In protracted cases, however, and especially when there is a good deal of bronchial irritation, it may be very copious, thick, and ropy, more or less opaque, of a dirty, rust-colored aspect, or tinged with blood. When cavities form around the foreign body, whether from gangrene, or from the softening of tubercular matter, the expectoration is generally almost insupportably offensive.

Sometimes the patient throws up blood, either pure or mixed with frothy matter. The quantity is usually very small, not exceeding a few drachms. The accident may occur immediately after the introduction of the foreign substance, or not until serious structural changes have taken place in the lungs.

The pain which follows this accident is generally very slight, except when the resulting inflammation has produced serious structural lesion. In its character, it may be sharp and pricking, or dull, heavy, and aching; it may be limited to the seat of the foreign body, or it may pervade the trachea, larynx, bronchial tubes, and lungs, if not also the throat, œsophagus, and muscles of the chest. It is commonly accompanied by a sense of constriction, tightness, or suffocation, and is liable to be aggravated by coughing and the slightest change in the situation of the foreign body. It is occasionally fixed for a long time at one spot, and then suddenly shifts to another. Sometimes, again, it remains at its original site for a considerable period after the extrusion of the foreign substance.

Instead of pain, there may merely be a feeling of soreness. This may occur at various points of the respiratory apparatus, and is, perhaps, more frequently present than is commonly imagined, owing to the want of a thorough examination, or the fact that the patient is not always able to indicate the nature of his sufferings.

No substance can remain for any length of time in the air-passages without causing more or less serious disturbance in the respiratory functions. The patient has hardly escaped from the immediate effects of the accident before his life is endangered by inflammation, which, if not promptly relieved, may speedily prove fatal. This effect, which is always to be dreaded in every case of the kind, devolves upon the attendant the absolute necessity of frequent examinations of the chest, both by auscultation and percussion.

One of the most remarkable circumstances after this accident is that, while the patient can freely inspire, he often finds it almost impossible to expire. This is particularly the case when the foreign body lies in one of the bronchial tubes, which may thus be almost completely closed, neither allowing the air to enter nor

to pass out. Nevertheless, as the other canal remains free, inspiration may be carried on with considerable vigor, whereas every attempt to expel the air from the obstructed lung will be attended with great suffering and a feeling of exhaustion. If, under such circumstances, the ear be applied to the chest, the respiratory murmur on the affected side will be found to be either entirely inaudible, or but faintly appreciable, while on the sound side it will either be perfectly natural, more or less puerile, or characterized by various râles. Whenever this happens, the thorax will be found to be everywhere perfectly clear on percussion; the reverse being, of course, the case when there is hepatization from disease, or excessive engorgement of the pulmonary tissues, as will necessarily occur, in nearly every instance, within a short time after the foreign body has reached the air-passages. Occasionally, the air, as it rushes by the foreign body, produces sounds so peculiar that they may be regarded as pathognomonic of the nature of the affection. Thus, in a case observed by Mr. McNamara, of Dublin, the noise resembled that produced by blowing through a whistle, the foreign substance, a plum-stone, being perforated at the middle. Occasionally, the substance, as it plays up and down the windpipe, produces a peculiar flapping sound. Finally, the symptoms may be of an asthmatic character.

The posture of the patient varies. Generally he finds it most agreeable to sit up; for as soon as he attempts to lie down he is seized with increased embarrassment of breathing, with a disposition to cough and a feeling of suffocation: during sleep he is, consequently, obliged to be propped up in bed, or to rest in a chair. Sometimes, however, he lies best on his back, or on one side.

The general health is variously affected; sometimes lightly, sometimes severely, sometimes, again, not at all. In most cases, however, even when the foreign substance is not retained beyond a few days, the system is feverish, the appetite and sleep are interrupted, and there is an anxious expression of the features. If the irritation continues, inflammation of the lungs and air-tubes soon takes place, with an aggravation of the cough, emaciation, and loss of strength.

Diagnosis.—As these accidents occur most frequently in infants and children, who can but ill express their feelings, one of the first duties of the practitioner is to inquire, most carefully and circumstantially, into the history of the case. Very frequently some time elapses before he can reach the patient, or it may be that, although the interval between the occurrence and his visit may be very short, the first symptoms may have entirely disappeared, and the patient act and feel as if nothing had taken place. Now, it is just in such cases as these that errors are most liable to happen, for the reason that the professional attendant, seeing that there is apparently nothing the matter, allows his mind to be lulled into a state of security, frequently not less injurious to himself than destructive to his patient. It is different with adults, who are usually conscious of the time and manner of such accidents, and who, therefore, rarely fail to give a correct account of them.

If the patient, supposing him to be a child, has been playing with a grain of corn, bean, pebble, or similar body, and has been suddenly seized with symptoms of suffocation, violent spasmodic cough, lividity of the face, pain in the upper part of the windpipe, and partial insensibility, there will be a strong presumption that the substance, whatever it may have been, has slipped into the air-passages, and is the immediate and only cause of the suffering. The presumption will be converted almost into positive certainty if the child was just previously in the enjoyment of good health; if he was romping, jumping, or laughing at the moment of the accident, with the substance, perhaps, in his mouth, or while attempting to throw it into that cavity; and especially, if the symptoms, after having been interrupted for a few minutes, continue to recur, with their former, or even with increased, intensity, at longer or shorter intervals. The symptoms here enumerated, however, are sometimes most painfully simulated by the cough and embarrassment of breathing occasioned by cold and other affections. The difficulty in arriving at a correct diagnosis is still further augmented, in some of these cases, by the coincidence of the respiratory trouble and the fact of the child, at the moment of the seizure, having been engaged in playing with a substance such as that above mentioned.

Important information may frequently be obtained by auscultation and percussion, particularly when the foreign body is situated in the lower extremity of the trachea,

or in one of the bronchial tubes, where, especially if it is bulky, or firmly impacted, it must necessarily affect, more or less seriously, the respiratory functions, and thus manifest itself by the alterations which it induces in the sounds of the lungs and chest. These alterations are always less distinct, and they may even be entirely absent, when the extraneous substance occupies the larynx, or the upper portion of the trachea.

A stethoscopic examination, however, although generally useful, does not always afford satisfactory evidence of the nature of the affection, as I know from the observation of several instances, in none of which, notwithstanding the most careful and repeated exploration, could the situation of the intruder be determined. Two circumstances may be mentioned as likely to occasion such a result. In the first place, the auscultatory signs may be masked by previous disease, or by disease awakened by the accident, as inflammation of the windpipe, lungs, or pleura; and, in the second, the patient, especially if a child, may offer such resistance, either by his cries or struggles, as to render it utterly impossible to make a thorough investigation. In the latter case, the obstacle may, fortunately, always be promptly and effectually surmounted by the use of chloroform.

Some inference, too, of a diagnostic character, is generally deducible from the nature of the foreign substance. Ponderous bodies, such as bullets, shot, metallic buttons, pebbles, and pieces of coin, generally at once descend into the bronchial tubes, from which they are afterwards unable to rise in the act of coughing, sneezing, or other violent expiratory efforts, as bodies are liable to do when they are of an opposite description.

If the foreign body is large, and at the same time very rough, angular, or spiculated, it will probably be arrested in the larynx or trachea. A similar occurrence may be expected if it be long and narrow, as in the case of a needle, pin, nail, or fish-bone, unless it should happen to enter the glottis vertically, when it may at once fall into one of the bronchial tubes.

In some instances, as stated elsewhere, the foreign substance is capable of producing a peculiar noise, occasionally detectable even at a distance from the patient's body.

No definite information can be derived from the state of the voice when the foreign body lies in the trachea or in one of the bronchial tubes. Under such circumstances, it may be more or less changed, or, in rare instances, perhaps be even entirely absent; but as the alterations are not peculiar, but altogether similar to those produced in ordinary affections of the air-passages, it is evident that they are of no diagnostic value. The reverse, however, is the case when the foreign substance is retained within the larynx; for then the changes in the vocal functions, if not actually characteristic, may, in conjunction with other symptoms, afford most important, if not conclusive, information.

The pain accompanying this accident cannot be regarded as diagnostic, inasmuch as it may be produced by other causes, as inflammation, neuralgia, or spasm of the air-passages.

The symptoms of extraneous bodies in the respiratory organs may be imitated by different diseases, either directly affecting these organs or acting upon them sympathetically. Of these diseases the most important are croup, whooping cough, ulceration of the larynx and trachea, aneurism of the aorta, and worms in the intestines.

It is generally easy to distinguish between the symptoms of a foreign body and those of spasmodic croup, by observing that, in the latter affection, the chief difficulty of breathing exists during inspiration, while in the former it exists during expiration. Important information may also be derived from the state of the voice, which is usually characteristic in croup, and from the state of the pulse and skin, which are rarely excited until after the extraneous substance has had time to cause inflammation and sympathetic irritation, whereas they are usually more or less seriously disturbed at an early stage in laryngeal disease. Besides, in the latter affection, the symptoms are continued, whereas in the case of a foreign body in the air-passages, there are frequent intermissions, followed by sudden aggravations of suffering. Professor J. B. S. Jackson has communicated to me the particulars of two cases, in which the symptoms produced by foreign bodies in the air-passages were mistaken for those of membranous croup.

Alarming symptoms, simulating those of a foreign body in the air-passages, may arise during an attack of whooping cough. Here mistake may be prevented, first, by

a careful consideration of the history of the case; secondly, by the existence of the peculiar hoop, which is always wanting in the former affection; and, lastly, by the fact that the embarrassment of breathing occurs in this disease, as in croup, not during expiration but inspiration.

Spasm of the glottis, by producing suffocation, may give rise to symptoms simulating those of a foreign body in the windpipe. A common cause of this is ulceration of the larynx. If such an occurrence should take place while the patient is eating, it would be very natural to ascribe it to the presence of a foreign body in the air-passages, although they might be entirely free from mechanical obstruction. The diagnosis, in such an event, would, of course, be extremely difficult, if not impossible. The history of the case might furnish some clue, but hardly any of a satisfactory character. Upon whatever cause the symptoms depend, tracheotomy alone, performed without delay, would be likely to save the patient.

Similar embarrassment may arise from an aneurism of the thoracic aorta. The pressure of such a tumor may produce great narrowing both of the trachea and of the bronchial tubes, particularly the latter, thereby seriously impeding the passage of the air to the lungs. The diagnostic signs, in cases of doubt, are the gradual approach and persistent character of the symptoms in aneurism, and their sudden, violent, and intermittent character when occasioned by the presence of an extraneous substance. Moreover, it is worthy of note that such accidents are most frequent in children, while aneurism of the thoracic aorta is almost exclusively confined to elderly subjects.

The sympathetic irritation induced by worms in the alimentary canal may closely simulate the phenomena produced by the presence of a foreign substance in the windpipe. The most certain diagnostics, in circumstances of doubt, are the history of the case, and the prompt relief which usually follows the exhibition of anthelmintic remedies, when the affection is of a verminous character; and the failure of these means, when the symptoms depend upon the presence of a foreign body.

Symptoms, closely resembling those produced by foreign bodies in the air-tubes, may be caused by the lodgment and impaction of extraneous substances in the pharynx and œsophagus, often exciting violent, if not fatal, spasm of the glottis.

Finally, it is well known that, if a foreign body, such, for instance, as a piece of meat, or cartilage, is retained even for a short time in the œsophagus or fauces, the irritation occasioned by its presence will often remain for hours, if not days, after its removal. Such is the distress sometimes, under these circumstances, that it is very difficult to persuade the patient that the substance is not still in its original situation; and hence, as the same thing may occur when the foreign body is in the windpipe, the surgeon, unless he is fully on his guard, may be led into most serious error.

It is not always easy to determine, from a consideration of the history and symptoms of the accident, whether the offending substance is in the larynx, or in some other portion of the windpipe. From an analysis of sixteen cases, I am led to conclude that, as a general rule, whenever there is aphonia, whether partial or complete, the substance is situated in the larynx; at all events, there is a strong probability of this, a probability converted into certainty, if, conjoined with this symptom, there is pain, soreness, or uneasiness in the region of the larynx, along with dyspnoea, a whistling sound in respiration, absence of serious disease in the bronchial tubes and lungs, and inability to perceive the offending body moving up and down the trachea. It is important, however, to bear in mind that the voice may be seriously affected, and yet the foreign body not be lodged in the larynx, but in the trachea, or in one of the bronchial tubes. In case of doubt recourse should be had to the laryngoscope, which sometimes enables us to see the intruder with the greatest facility, as in the cases reported by Czermak, Gibb, Türck, Beigel, and others.

When a foreign body descends into one of the bronchial tubes, the respiratory murmur in the corresponding lung is generally more or less affected. The wall of the chest, however, is not always, perhaps not even generally, dull or flat, as in pneumonia and phthisis, in which the parenchymatous substance of the organ is condensed by abnormal deposits; on the contrary, the sound is frequently unnaturally clear and resonant, very much, indeed, as in pulmonary emphysema. This peculiarity may involve the entire lung, or it may be limited to particular portions, as one-half, a third, or one-fourth, according to the size and situation of the foreign body. When the extraneous substance is so large as to obstruct the bronchial tube com-

pletely, there must necessarily be marked dullness on percussion, and great diminution, if not entire absence, of motion in the ribs.

The respiratory murmur, under the same circumstances, may be very much diminished, or wholly absent, according to the amount of the pulmonary obstruction. In most instances it is lessened only somewhat in intensity, because a certain quantity of air still enters the lung by the side of the foreign body. It is only when the extraneous substance is very bulky, or when the tube is completely closed by it, or partly by it, and partly by abnormal deposits, as mucus, pus, or lymph, that the respiratory murmur can be no longer recognized, or only in the most imperfect manner.

The extraneous substance may, as already stated, change its place in consequence of the impulse which it receives during coughing, during violent expulsive efforts of the lungs, or even during the various movements of the body. Thus, in one of my cases, the foreign body, a grain of corn, was impacted for upwards of a week in the right bronchial tube, when suddenly, in a severe paroxysm of coughing, it passed over into the left, where it was discovered on the dissection. Its former presence on the right side was denoted not only by the alterations in the respiratory murmur and by the extraordinary resonance on percussion, but by the peculiar pathological appearance of the mucous membrane in the corresponding bronchial tube. It should also be recollected that the changes in the respiration may be materially influenced, if not entirely masked, by the deposits produced by the irritation of the foreign substance, thus frequently divesting them of their diagnostic value.

The foreign body occasionally plays up and down the trachea, either in consonance with the respiratory movements, or in consequence of severe fits of coughing. During these changes, it is very liable to cause severe spasm and irritation by impinging against the mucous membrane of the larynx, sufficient, in some instances, to induce suffocation. The patient, in many of these cases, is rendered conscious of this occurrence, not only by the pain and spasmodic cough, but by the peculiar sensation which the substance produces as it passes up and down the windpipe. Sometimes, again, the extraneous body may be distinctly felt and even heard during these movements, as in an interesting case communicated to me by Professor May, of Washington. The patient was a child five years old, in whom the substance, a grain of corn, was perceptible at every expiration as it struck the upper part of the trachea.

Occasionally, the noise produced by the foreign body, or, more properly speaking, by the air, as it rushes past it, is so peculiar that it may be regarded as pathognomonic of the nature of the accident. The sound may be of a whistling nature, a cooing rhonchus, or a peculiar flapping.

The preceding facts will commonly serve to show whether the foreign substance is firmly impacted in one of the bronchial tubes, or whether it is capable of moving up and down the trachea during coughing and respiration. As a general rule, the substance, whatever it may be, remains loose. This is often true in cases even of long standing, but it is particularly so of recent ones, before the occurrence of much secretion, tending to attach the foreign body or to impair its mobility, and before the development of serious structural lesion, as, for example, the formation of an abscess, in which the body may become permanently imprisoned. When, to the above facts, we add the absence of all laryngeal disease, and the unaffected state of the voice, the conclusion will be inevitable that the intruder is lodged in one of the bronchial tubes, or alternately in one of these tubes and in the trachea.

I do not think it is possible to determine, from anything we know, whether a foreign body is permanently arrested in the trachea. The number of such accidents is exceedingly limited, and the phenomena attending them have not been studied with sufficient attention to justify the deduction of any special conclusions.

Spontaneous Expulsion.—Almost every possible variety of substance, capable of entering the windpipe, may be spontaneously expelled. In my Treatise on Foreign Bodies in the Air-Passages, I have given the particulars of numerous cases illustrative of the subject. Among the more ordinary substances may be mentioned cherry-stones, nuts and fragments of their shells, water-melon seeds, beans, grains of corn and of coffee, bits of bone, nails, and tacks; among the more uncommon, teeth, pieces of coin, bullets, cockle-burs, and ears of grass and grain. Professor Hamilton has communicated to me the particulars of an instance in which a tin whistle was spontaneously ejected. Nunn, Colles, and Heustis have, respectively, reported cases in

which riddance was thus effected of a puff-dart, a pop-gun, and a piece of feather nearly two inches in length.

The expulsion usually occurs in a paroxysm of coughing, and the effort is, no doubt, greatly facilitated by dependency of the head, as when it is hanging over the edge of the bed. In forty-nine cases, tabulated in the work above referred to, riddance was effected, in this manner, in thirty-seven; in one, in sneezing; in one, in dreaming; and in one, in spontaneous vomiting; the mode of expulsion in the remainder not being mentioned. Two cases have been communicated to me of the spontaneous expulsion of bullets in the act of coughing; and several examples in which shot were similarly disposed of, are upon record. In all these instances, the patient's head was at the moment in a dependent state.

The time at which the expulsion occurs varies from a few hours to many years. In a case reported to me by Professor Flint, nearly three years elapsed; and in another, for which I am indebted to Dr. Wulkupf, the interval was upwards of eleven years. Although the patient generally recovers after riddance has been effected, he now and then perishes from the injury sustained by the sojourn of the foreign substance, as inflammation of the lung, or of the lung and pleura. In a case mentioned by Lescure, in which the foreign body, a piece of bone, was expelled at the end of seventeen years, death occurred in eighteen months, from pulmonary disease. On the other hand, the lung may be greatly disorganized by the foreign substance, and yet complete recovery ensue, as in the case of a boy, upwards of eleven years of age, whom I saw with Dr. Rodman and Dr. Bryan, and in whose lung there was a large cavity, the result of gangrene.

The expulsion usually takes place by the glottis; but now and then through the walls of the chest. In the former case, the substance generally escapes with a good deal of force, in a violent expiratory effort or in a paroxysm of coughing. In children, the substance is occasionally swallowed, thus creating a painful state of uncertainty in regard to its disposition, perhaps only relieved by finding it in the alvine evacuations.

Treatment.—The treatment of foreign bodies in the air-passages is medical and surgical; the former being intended to protect the patient from suffocation and disease of the respiratory organs, the latter to effect riddance of the intruder.

An individual who has a foreign body in his windpipe should be regarded as an invalid, unfit to leave his room, or to attend to business. The treatment, in the early stage of the complaint, should be limited to a general supervision of the patient's health; that is, his diet should be carefully regulated, the bowels moved from time to time with mild purgatives, and the temperature of the apartment uniformly maintained at about 75° of Fahrenheit. The chest should be thoroughly examined at least once a day by auscultation and percussion, to ascertain the condition of the lungs and bronchial tubes. Cough should be subdued by mild expectorants, containing, if there are frequent spasms, a suitable quantity of morphia. If symptoms of pneumonia, bronchitis, or pleuro-pneumonia supervene, they must be promptly met by the ordinary remedies, particularly the lancet, active purgatives, and tartar emetic, in conjunction, if necessary, with leeches and blisters. By watching the patient in this way, the respiratory organs may be protected from mischief, and the extraneous substance be expelled spontaneously; or, should an operation become necessary, he will be in a much better condition to undergo it with impunity.

The expulsion of the foreign body does not always secure immunity from danger. The air-passages, irritated by its presence, may have taken on inflammation before its extrusion, or this action may be set up soon after, and in either case the danger to life may be very great.

As it respects the use of emetics, experience has shown that they are not only useless, but often dangerous, by impelling the foreign body into the larynx, and thus causing violent spasm of the glottis. Besides, their employment may occasion loss of valuable time. In forty-six cases, analyzed by me, in which various articles of this kind were exhibited, there was not one in which they were of any material service, while in a considerable number they were positively injurious.

Sternutatories of every description, mild and harsh, vegetable and mineral, have been employed, with a view of aiding the expulsion of the intruder, but, with the exception of the case related by Boyer, in which the nose was tickled with snuff, while the patient was partially asleep, no relief followed their use. It is possible that this class of remedies might occasionally be beneficial, if conjoined with the use of chlo-

roform. The proper plan would be to make the patient inhale the fluid until he is nearly insensible, and to irritate the Schneiderian membrane with snuff, or some other substance, the moment he begins to regain his consciousness. Should sneezing ensue while he is in this condition, with the air-tubes in a state of perfect relaxation, it is easy to conceive that the foreign body might be ejected. Nature would be taken, as it were, by surprise, as she has sometimes been by a dream, as in the remarkable case of Mr. Cook.

A very interesting case, in which a piece of fish-bone was expelled from the windpipe under the influence of the inhalation of iodine, occurred in 1832, in the practice of Mr. Day.

Inversion of the Body.—This operation, as the name implies, consists in suspending the patient by the heels, or in securing his body, with the head inclined downwards, to a chair, narrow table, or other suitable object. While in this position, the chest and back are repeatedly and smartly struck with the hands, to aid, first, in dislodging the offending substance, and, next, in propelling it through the glottis, or, in case of bronchotomy, through the artificial opening in the neck. With the same view, the thorax is sometimes suddenly and forcibly compressed, the patient having previously taken a full inspiration. The object of this manœuvre is to empty the lungs as rapidly and completely as possible, in order that the air, as it rushes through the windpipe, may carry the intruder before it. The compression is usually effected with the hands, applied at opposite points of the trunk; but, perhaps, a better method is to make it with a broad bandage, arranged so as to encircle the chest, and slit at the ends, after the fashion of the bandage used in tapping the abdomen. The patient having taken a full inspiration, the extremities of the bandage are suddenly drawn in opposite directions, thereby compressing the thoracic walls equably and forcibly at every point.

The great objection to this operation is the risk the patient incurs from suffocation, occasioned by spasm of the glottis, from the contact of the extraneous body in its attempt to pass through the larynx. The only way of preventing this is either to administer chloroform, or, what is preferable, to open the windpipe as a preliminary measure. By this procedure, all danger of producing spasm of the glottis will be avoided, and the foreign body will have a chance of escaping either through the larynx, or at the wound in the neck. Without this precaution, inversion of the body, unless practised with the greatest possible care, may be attended with very serious, if not fatal, consequences.

In the interesting case of Mr. Brunel, recorded by Sir B. C. Brodie, inversion invariably produced the most distressing cough, with symptoms of impending suffocation, compelling the experimenter at once to desist. The object was, by permitting the patient's head and shoulders to hang over a chair while the body was in the prone position, to afford the extraneous substance, a half-sovereign, an opportunity of slipping through the rima of the glottis into the mouth. During every effort of this kind, there was a distinct perception of a loose substance passing forward along the trachea, and striking against the larynx. Tracheotomy was afterwards performed, and an attempt made, but in vain, to extract the coin with the forceps. Finally, at the expiration of the sixteenth day after the operation, the patient's body and shoulders were secured to a peculiar contrivance, a sort of platform, made movable on a hinge in the centre, and so arranged as to permit the head to be brought to an angle of about 80° with the horizon. The back being now struck with the hand, severe coughing ensued, followed almost immediately by the ejection of the intruder.

Extraction by the Mouth.—Since the laryngoscope has been applied to the investigation of affections of the upper part of the windpipe, several cases have occurred in which foreign bodies have been promptly and successfully extracted by the aid of this instrument through the mouth. Thus, in the instance of a man, thirty-six years old, treated by Dr. Beigel, a bean, lodged at the anterior angle of the vocal cords, was readily seized and removed with the forceps, after its previous detection with the laryngoscope. Dr. Minshull, in a similar manner, in 1870, extracted a penny that had been impacted for six years in the larynx of a lad, sixteen years old. More recently several other successful examples have been reported. It may well be supposed that the extraction of a foreign body through the mouth, with the aid of the laryngoscope, must require an immense amount of skill on the part of the surgeon, and the most perfect coöperation on the part of the patient. The operation

is, of course, only applicable to cases in which the substance is lodged within the larynx, more particularly its superior portion.

Operative Interference.—It is very important, before operative interference is employed, to explore the throat, as the foreign body may lie at the very entrance of the larynx, and admit of ready removal with the finger. The case of Gilbert, so graphically described by Richerand, painfully illustrates the sad effects of such an omission. This unfortunate young man, in a fit of insanity, locked up his manuscripts in a press, to prevent them from falling into the hands of his enemies, and then swallowed the key. It lodged in the mouth of the windpipe, prevented the entrance of air, and suffocated him after three days of the most cruel suffering. Pieces of meat, bone, bread, potato, and other substances are often arrested here, and, if not speedily removed, are almost sure to cause asphyxia, either by direct occlusion, or by the induction of spasm in the muscles of the larynx.

Having satisfied himself that the foreign body is in the air-passages, the sooner the windpipe is opened the better. For the want of this precaution, I have known a number of children to be lost, in the vain hope that extrusion might occur spontaneously. A violent cough coming on, the patient may drop down in a fit of unconsciousness, from spasm of the glottis, and be instantly choked to death. Now, although the operation may not be immediately followed by the escape of the foreign body, it will at least effectually prevent spasm of the glottis, and thus afford the extraneous substance an opportunity of being extruded either by the natural or artificial route. The patient has thus two chances of coughing it up, whereas, before, he had hardly one, the contraction of the muscles of the larynx constantly acting as a barrier to its escape. Even when the wound finally closes, without the foreign body being expelled, the operation may have been of the greatest possible benefit in preventing suffocation.

The operation usually selected is tracheotomy, as it affords much easier access to the foreign body than laryngotomy, as well as a much better chance for its spontaneous expulsion. The latter operation, however, should always be selected when it is certain that the substance is impacted in one of the ventricles of Morgagni, unless the patient is a child, with a very short, thick neck, rendering it difficult to obtain a sufficiency of room for the easy introduction of instruments. The incision in the trachea may occasionally be advantageously prolonged into the larynx, and conversely. In laryngotomy it is sometimes extended upwards through the greater portion of the thyroid cartilage. The manner of executing these operations, for this and other purposes, will be described under a distinct head. When they are performed for the removal of foreign bodies, the patient should always take chloroform or ether, and the whole proceeding should be conducted in the most careful and deliberate manner.

The moment the operation is completed, the patient is turned upon his abdomen, with the face towards the floor. The object of this procedure is to relax the edges of the wound, so as to afford a freer passage for the escape of the foreign body, and of any blood that may have accidentally entered the windpipe. If the patient is partially asphyxiated, the wound should be kept open with a pair of polyp-forceps. In a case of this kind lately under my charge, the foreign body, a large pebble, was projected into the blades of the instrument, while in this position, and at once extracted. Its size was such as almost to close the trachea, and the child, who was only three years of age, evidently had not the power to expel it.

If the substance be not speedily ejected, the best plan is to invert the patient's body, and to strike the chest with the hand, or with a pillow, especially if the intruder be a ball, coin, shot, pebble, pea, bean, water-melon seed, plum-stone, cherry-stone, button-mould, or similar article. Inversion of the body, with previous opening of the tube, is a comparatively safe operation. Succussion and percussion are important auxiliaries in such an event.

If these measures fail, search should be made for the substance with the finger, forceps, or hook; but all such attempts must be conducted in the most gentle manner, nor should they be prolonged beyond a few seconds at a time, inasmuch as they almost invariably excite violent cough and suffocative feelings. The employment of chloroform and the bending of the head will greatly facilitate this step of the procedure. The finger can only be advantageously used, as a means of exploration, when the foreign body lies in the trachea or larynx, in connection with a large wound.

An operator sometimes makes a fortunate hit with the forceps, as in a remarkable case treated by Dr. J. D. Lyman, in which, in an attempt to remove a bullet which had cut its way through the right side of the larynx, and lodged in the neck, the missile accidentally slipped out of the grasp of the instrument into the trachea, causing most violent suffocative symptoms. The opening was at once enlarged, and the bullet seized at the bifurcation of the windpipe.

The foreign body, both in laryngotomy and tracheotomy, may escape either at the artificial opening or by the glottis, and, in either case, it may be thrown to a considerable distance, perhaps the very moment the tube is pierced; or it may be intercepted by the edges of the wound; or it may, if it take the natural route, lodge in the mouth, or pass into the stomach.

Great care is taken not to permit any blood to enter at the artificial opening, as the smallest quantity may not only induce violent cough and spasm, but instant suffocation. Should the accident be unavoidable, the patient must immediately be turned upon his abdomen, and, if necessary, the blood must be sucked out of the tube with the mouth. It is worthy of remark that the thyroid veins, which are generally so much distended in consequence of the difficulty of breathing and the struggles of the patient, often cease to bleed the moment the windpipe is opened and the air is freely admitted into the lungs.

When the patient is asphyxiated, whether by spasm of the glottis or by the presence of blood in the windpipe, the only resource is artificial respiration, steadily and diligently maintained until there is reason to believe that life is completely extinct. In a remarkable case observed by Dr. J. F. May, the artificial respiration was kept up for half an hour before the child, a boy nearly three years old, evinced signs of returning life. The air may be introduced by the application of the operator's mouth, or, what is far better, by means of a gum-elastic tube, inserted through the wound into the trachea.

When the extraneous body refuses to escape, or resists the efforts at removal, the edges of the tracheal wound should be kept apart by means of blunt hooks, in order to favor extrusion. No canula should be inserted, as it would seriously interfere with the expulsion of the extraneous substance. The outer wound should be covered, in this case, with a piece of gauze, arranged in the form of a bag, to prevent the ingress of flies and dirt.

Riddance having been effected, the wound is closed with adhesive strips, aided, if necessary, by a few interrupted sutures, care being taken not to carry them through the substance of the trachea. Simple water-dressing is the best application, but even this may, in general, be omitted.

The after-treatment must be strictly antiphlogistic; the respiratory organs must be diligently watched; and the air of the patient's apartment must be both moist and warm, the temperature being steadily maintained at 80° to 85° of Fahrenheit. Should difficulty of deglutition supervene, as often happens from the third to the fifth day, it will be proper to avoid the use of fluids, inasmuch as they will have a tendency to enter the windpipe in consequence of the impaired condition of the epiglottis. No patient is safe, or out of danger, after this accident, so long as there is inflammation of the respiratory passages, whether the intruder has been expelled or not.

Bronchotomy does not always insure the speedy expulsion of the offending body; on the contrary, cases not unfrequently arise where the only apparent good from it is the relief which it affords from spasm of the glottis, the extraneous substance being, perhaps, either permanently retained, or, at any rate, not ejected until some time afterwards, occasionally, indeed, not until the wound is entirely cicatrized, as happened in one of my own patients. On this account it might become necessary to perform the operation a second and even a third time.

Instruments.—Various instruments have been contrived for effecting the dislodgment and removal of foreign bodies. Of these, a few of the most eligible and important require particular notice.

1. Fig. 302 represents a pair of forceps, constructed for me by Mr. Kolbé, after a model of my own. They are composed of German silver, and are a little upwards of eight inches in length. The handle is considerably curved on the flat, and has two large rings for the thumb and finger. The blades, which are rounded and very slender, are five inches long, and terminate each in a fenestrated extremity, nine lines in length by three lines in width, the outer surface being smooth and convex,

the inner flat and slightly serrated. The great advantages of this instrument are, first, that it may be used with equal facility as a probe and an extractor; secondly,

Fig. 302.



Trachea Forceps.

that it may be bent at any point and in any direction, according to the pleasure of the operator; and, thirdly, that it cannot possibly seriously impede the passage of the air, during the attempts which are necessary to explore the windpipe for ascertaining the precise situation of the foreign substance.

Fig. 303.

Fig. 304.

Fig. 305.

Fig. 306.



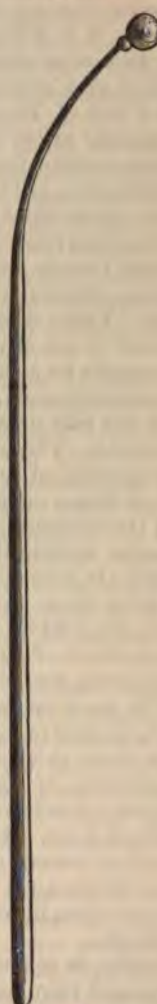
Trousseau's Forceps.



Blunt Hook.



Probe.



Sponge Mop.

2. The forceps, delineated in fig. 303 are intended for holding apart the edges of the wound in the trachea, while the surgeon attempts to extract the foreign substance

with other and more suitable instruments, introduced between their expanded blades. I have repeatedly found them very serviceable.

3. Fig. 304 represents a long, slender hook, composed of silver, and well adapted for extracting foreign bodies, as beans, grains of corn, coins, prune-stones, pebbles, and bits of bone, situated in the inferior portion of the trachea, or in one of the bronchial tubes. The curved part of the instrument is very short and blunt at the extremity.

4. For exploring the air-passages, or dislodging foreign bodies from the larynx, especially the ventricles of Morgagni, hardly anything better could be imagined than the probe sketched in fig. 305. It is about nine inches in length, bulbous at the extremity, and, as it is composed of silver, any curve may be imparted to it that may be desirable.

5. The instrument delineated in fig. 306 is merely a whalebone probang, bent at an angle of about 45° , and surmounted at its extremity by a small piece of very soft sponge. It is admirably adapted for removing extraneous matter from the larynx, and should find a place in every surgeon's drawer.

6. Another instrument which the operator should have at hand, especially when the extraneous body is impacted in one of the ventricles of the larynx, is a flexible, grooved director, such as is usually found in the common pocket case. The scoop-shaped extremity may be used with great advantage under such circumstances, particularly if it is slightly bent.

7. In a case under the care of Dr. John L. Atlee, the foreign body, consisting of a piece of clay pipe-stem, an inch and a half long, was readily seized and extracted with a pair of Toynbee's ear forceps, one of the blades of which happily slipped into the interior of the tube, and thus enabled the operator to take a firm hold of it. The patient, a child four years of age, recovered without any untoward symptoms.

Difficulties.—The difficulties experienced in these operations, especially in tracheotomy, arise chiefly from the imperfect manner in which the patient's head is held, extraordinary shortness and thickness of the neck, uncommon turgescence of the cervical vessels, or irregularity in their distribution, ossification of the rings of the trachea, enlargement of the thyroid gland, and, finally, the occurrence of hemorrhage. These difficulties may usually be easily obviated by proper care. The rule is never to cut anything that can be avoided, but to hold it out of the way; and if any vessels be accidentally opened, they must immediately be ligated.

In laryngotomy, the crico-thyroid artery, a small branch of the superior thyroid, about the size of a crow-quill, is necessarily divided as it crosses the crico-thyroid membrane. The proper plan is not to open the tube until the vessel has been tied. I am cognizant of several cases in which, from the want of this precaution, the patient died of hemorrhage.

In tracheotomy, the bleeding may proceed from the tracheal plexus of veins, or from the middle thyroid artery, given off either by the innominate or the common carotid; in some instances it is double, one offset being derived from the former, and the other from the latter, vessel. In a preparation in the possession of Dr. S. W. Gross, the middle thyroid arises from the left subclavian, about three-quarters of an inch in front of the thyroid axis.

Although the hemorrhage in tracheotomy is usually insignificant, it may occasionally be very profuse, if not fatal; only so, however, in the hands of an ignorant, timid, or inexperienced operator. I have heard of at least half a dozen cases of death from this cause. Sometimes a very considerable flow of blood follows upon the division of the mucous membrane, especially when it is highly congested or inflamed, as it is very liable to be when the foreign body has been retained for any length of time. The hemorrhage will then, of course, be internal, and may proceed to such an extent as to induce the most serious impediment in the respiratory functions. When such an occurrence is threatened, the patient should instantly be placed upon his face, in order that the fluid may escape at the artificial opening as fast as it is effused.

Finally, in opening the trachea, it should be borne in mind that the innominate artery and vein may ascend unusually high up in the neck, or that they may cross this tube in such a manner as to incur the risk of being injured by the incautious use of the knife, as in the celebrated case recorded by Desault, in which death was produced from a wound inflicted upon the former of these vessels.

Contra-indications.—Under no circumstances should bronchotomy be performed without a thorough exploration of the chest and œsophagus. It should be remembered, as already stated, that mere spasm of the glottis, caused by the lodgment of a foreign body in the fauces or gullet, or by derangement of the digestive, respiratory, and nervous systems, may induce a train of phenomena closely resembling those occasioned by the presence of a foreign body in the air-tubes.

An important question here presents itself, At what period after the occurrence of an accident of this kind should an operation be considered as improper? Or, more properly speaking, what are the circumstances which contra-indicate a resort to the knife? It must be obvious that the mere lapse of time should not be taken into the account in the decision of such a question; for it is well known that one individual may experience as much damage from the presence of a foreign body in a week as another may in a month or a year. Thus, to particularize, the lungs may become seriously diseased, if not partially disorganized, in a few days, in one case, while in another they may suffer little, if, indeed, at all, during any stage of the accident. Hence, in every instance of the kind, a careful and thorough examination of the chest should be instituted as a preliminary step, with a view of ascertaining the precise condition of the respiratory apparatus. If this be found to be healthy, or even comparatively healthy, an operation, all other things being equal, would not only be justifiable, but highly proper, whatever length of time might have elapsed since the inhalation of the extraneous substance; if, on the other hand, it be seriously diseased, the knife should be studiously withheld, certainly temporarily, if not altogether, on the ground that the artificial opening would be very likely to complicate the morbid action, and thereby greatly enhance the patient's danger.

Mortality from Foreign Bodies.—In the work already several times alluded to are recorded the particulars of 159 cases, in which spontaneous ejection took place in 57, 8 terminating fatally. Inversion of the body alone was successful in 5 cases, and unsuccessful in 6. Of 68 cases of tracheotomy, 8 died, and 60 recovered. Of 17 persons upon whom laryngotomy was performed, 13 lived, and 4 died. Laryngo-tracheotomy was practised in 13 cases; in 10 the operation was followed by recovery, and in 3 by death. Thus, of the 98 cases in which the windpipe was opened for the removal of foreign bodies, 83 were successful and 15 fatal, or in the ratio of about 5½ to 1.

From an analysis of 554 cases of foreign bodies in the air-passages by Mr. A. E. Durham, of London, it would appear that of 271 not subjected to surgical interference 115, or 42.5 per cent., died. Spontaneous extrusion took place in 164, of which 15 were fatal; 95 perished without ejection; 2 out of 7 recovered after the discharge of the foreign substance at a late period through thoracic abscess; and of 5 expulsions after emetics all recovered. In 283 cases operative measures were adopted, with a mortality of 70, or 24.8 per cent. Of 231 cases of tracheotomy, 170 recovered and 61 died; laryngo-tracheotomy in 20 cases resulted in 5 deaths; laryngotomy, followed by extrusion, was successful in 13 out of 14 cases, while of 3 cases of laryngotomy, without expulsion, all perished; inversion and succussion of the body were successful in the 12 instances in which they were resorted to, as was also direct extraction in 3 cases.

From the above summary it would appear that the best results followed surgical interference, the mortality after operation, in almost an equal number of cases, having been less by 17 per cent. than that where surgical measures were withheld. In the three operations performed in the above cases, the results were nearly equally favorable, the recoveries after tracheotomy having been 73 per cent., after laryngotomy 76 per cent., and after laryngo-tracheotomy 75 per cent. All these operations are, other things being equal, more successful the earlier they are performed, as there is then less disturbance of the respiratory organs.

The causes of death after bronchotomy are various. The most common, undoubtedly, is inflammation of the lungs, which, as already stated, is liable to arise at various periods after the accident, and which often makes great, if not destructive, progress before the operation is performed. When death results from this disease, it may occur soon after the windpipe is opened; or, as is, perhaps, more generally the case, it may be postponed for a considerable time; until, in fact, the wound is completely cicatrized.

Death is sometimes occasioned by an inordinate deposit of mucus at the former site of the foreign body, or in its immediate vicinity; it may also be produced

Fig. 307.



Perforation of the Larynx.

by apoplexy of the brain, and by hemorrhage into the air-passages.

The adjoining sketch, fig. 307, for which I am indebted to Dr. John Brinton, illustrates a very singular case of foreign body in the larynx, which I saw with him in October, 1856, in a boy nine years old, who, on the 24th of September, had inhaled the shell of a chickpea. The symptoms being urgent, tracheotomy was performed the next day, but no extraneous substance could be detected anywhere with the probe. Nearly three weeks after the accident, Dr. Brinton, satisfied that he had discovered the situation of the shell, enlarged the wound, which had been all along kept open with hooks, by dividing the cricoid cartilage and the cricothyroid membrane. Again, however, nothing of a reliable nature was found, notwithstanding a large probe was repeatedly pushed up into the fauces. The boy experienced some benefit from the operation, and was for awhile even under the impression that he had swallowed the intruder. He progressed favorably enough until the 5th of November, except that he had occasionally a spasmodic attack, which he was in the habit of relieving by holding the edges of the wound temporarily apart with a pair of curved forceps. At the time here alluded to, having a more violent paroxysm of dyspnoea than usual, he thrust the instrument forcibly through the posterior and lateral wall of the trachea, and

thus ruptured a small artery, the blood of which, descending into the trachea, caused instantaneous suffocation.

The shell, on dissection, was found to be firmly imbedded in the right ventricle of the larynx, a portion being hooked around the inferior vocal cord; it was three-quarters of an inch in length by four lines in width, was covered over with bands of lymph, and could not be detected by the probe carried upwards through the wound in the neck. An opening, the result, doubtless, of ulceration, existed in the posterior and lateral wall of the larynx, through which the boy had pushed the forceps so as to cause the fatal hemorrhage. The trachea was completely filled with blood.

XVII.—ASPHYXIA.

The aid of the surgeon is occasionally required in cases of asphyxia, apnoea, suffocation, or suspended animation. This condition of the system may be induced, first, by mechanical obstruction to the entrance of air into the lungs, as in submersion and strangulation; secondly, by the inhalation of certain gases, causing spasmodic contraction of the glottis; thirdly, by the want of a due supply of oxygen; and, lastly, by the introduction of gases, which, while they replace the air in the lungs, at the same time exert a powerfully poisonous influence upon the blood and nervous system.

The period at which death occurs from these several causes varies with many circumstances and can hardly be defined even in a general manner. In the case of some of the gases, the extinction of life is almost instantaneous, whether it be occasioned simply by closure of the glottis, or by the direct poisonous action of these vapors upon the system. In hanging, garroting, manual strangulation, and submersion, the average period of death, when no complications exist, as injury of the spinal cord, brain, larynx, or other important organs, ranges from one and a half to two minutes. Exceptional examples both of recovery and of death, of a very remarkable character, occur in all forms of apnoea. The immediate cause of death in drowning and in mechanical obstruction to breathing generally, is apnoea, suffocation, or insufficiency of air. Respiration being thus arrested, the blood is unaerated and, consequently, unfitted to support life, although the circulation may go on for a short time after breathing has completely ceased. Dr. Lefevre, of Rochefort, found that, among the Navarino sponge-divers, there was not one, accustomed as they were to their occupation, who could sustain submersion, on an average, longer than seventy-six seconds, while the pearl-divers of Ceylon, according to Mr. Marshall, can seldom remain under water with impunity more than about two-thirds of that time. From these facts, as well as

from experiments performed upon dogs, it may be concluded that asphyxia is induced under water in a very few seconds. Complete death, however, does not occur at once. Unless the person is overcome by fright, shock, apoplexy, concussion of the brain, or intoxication, he invariably makes an effort to save himself. In his struggles he rises to the surface, and draws in more or less air. If he is a good swimmer, and retains his presence of mind, a considerable length of time may elapse before he is fatally exhausted. As unconsciousness approaches, more or less water enters the lungs, as well as the stomach, thus greatly increasing the danger of suffocation. Syncope under immersion is favorable to recovery, as is shown in the case narrated by Dr. Wooley, of a girl who, while in this condition, fell into the water but recovered after having been submerged exactly six minutes. The presence, on the contrary, of foreign matter in the air-passages, as weed, sand, water, or even a large quantity of frothy mucus, necessarily accelerates death, as the lungs can neither receive nor expel air by respiration. When, at the moment of the submersion, the windpipe is completely plugged, the process may be continued longer without fatal results than when the occlusion is partial. Thus, if two dogs, of the same size and strength, be submerged, the one with the trachea completely closed, and the other with the tube open, the former will be much more likely to live when removed from the water than the latter, seemingly, because no water in this condition enters the lungs nor are the air tubes obstructed with frothy mucus.

The period at which a person after submersion may be resuscitated varies very much in different cases and under different circumstances. In some cases, for reasons not always explicable, recovery is found to be impracticable at the end of one minute. The chances are never good after submersion of twice this length of time, especially when the water and the air are both uncommonly cold. Occasionally, however, restoration is possible after a much longer period, as, for example, in the instance of Dr. Wooley, already referred to, and in another related by Mr. Jennings, where the patient was saved after having been under the water for twenty minutes. Dogs submerged for four minutes are effectually killed, although the heart may continue to beat for several minutes after they are taken out of the water. When reanimation after a very brief submersion is impracticable, it may generally be assumed that death is due to concussion of the brain, shock, apoplexy, congestion of the lungs, or spasmodic closure of the glottis.

The treatment of apnœa from drowning must be prompt and decided. Every moment of time is most precious. The body, being removed from the water to a dry place, is immediately stripped, wiped, and covered with a blanket, especially in cold weather. The mouth, nostrils, and throat are cleared of mucus, froth, and any other substances likely to interfere with the admission of air to the lungs; the tongue is pulled out at the corner of the mouth, and prevented from falling back upon the glottis; ammonia is rapidly passed to and fro under the nose; and the body is stretched out at full length with the face downwards, the forehead resting upon one arm, for the purpose of allowing any water that may be in the stomach and air-passages to escape by the mouth and nose. If these means do not speedily revive the patient, artificial respiration is instituted, the plan usually adopted, since the abandonment of that of Marshall Hall, being the one devised by Dr. Silvester, of London. For this purpose, the body being placed upon its back, with the head slightly elevated, the arms, grasped just above the elbows, are carried outwards and upwards from the chest almost perpendicularly, and retained in this position for about two seconds, the object of the procedure being designed to promote the introduction of air into the lungs as in natural breathing. They are then lowered and brought closely to the sides of the chest, where they are held for about the same length of time, in order to expel the air as during the act of expiration, the effort being aided by pressure applied to the inferior and lateral portions of the chest. These alternate movements of elevation and depression are repeated from twelve to fourteen times a minute, and are performed with all possible gentleness. As soon as signs of animation are observed, dry warmth should be applied to the extremities, the region of the heart, loins, and abdomen, a little brandy and water, or a few drops of aromatic spirit of hartshorn, being administered, or if deglutition be impracticable, thrown into the rectum. A warm bath at a temperature of 98° may be used, provided it can be done without worrying the patient. As soon as breathing is established, the body should be placed in bed, and carefully watched, a little warm broth, wine whey, or milk punch being given from time to time, as may be deemed necessary.

Dr. Benjamin Howard, of New York, who has devoted much attention to the subject of death by drowning, and to whom was awarded the prize for his essay on the "Treatment of Persons Apparently Found Dead from Suffocation," by the American Medical Association, in 1871, has modified the method of Dr. Silvester, in several important particulars, uniting drainage with direct manual compression of the chest. After having cleared away all mechanical obstruction, the patient is placed with his face downwards, with a large roll of clothing under his stomach, to promote the evacuation of the contents of this organ by the mouth and nostrils. As soon as this has been effected, the patient is turned on his back, and the roll of clothing is put underneath, opposite the lower extremity of the sternum, so as to render this the most prominent point. Artificial respiration is then instituted, an assistant pulling out the tongue and managing the arms very much as in the method of Silvester, while the surgeon, kneeling beside, or astride, the patient's hips, applies the balls of his thumbs on each side of the pit of the stomach, the fingers lying in the lower intercostal spaces. Using his knees as pivots, he throws all his weight forwards upon his hands, which, with a grasping effort made at the same time, effectually compresses the most yielding and elastic portions of the chest between the hands and the opposing roll of clothing. Gradually increasing the pressure for about two seconds, he suddenly relinquishes his hold with a kind of push, which restores him to the kneeling posture, in which he rests for a similar space, when he proceeds as before, repeating the alternate movements about fifteen times in a minute.

A very efficient contrivance for producing alternate contraction and dilatation of the chest, used by the Humane Society of London, is represented in the annexed sketch, fig. 308, and is known as Leroy's compressor. It is formed by

Fig. 308.



Leroy's Compressor.

tearing a piece of strong flannel or muslin, six feet in length by eighteen inches in width, into strips each two feet and a half long and two inches broad, the central portion being placed under the back, while the extremities, crossed in front and tied in a knot, are drawn by two assistants in opposite directions, thus imitating the natural movements of the thorax in respiration.

If, under any of the above procedures, signs of resuscitation do not speedily ensue, insufflation must, without delay, be employed, either by the mouth to mouth process, or by means of Leroy's apparatus. The former method is the more ready of the two, but it possesses the disadvantage of filling the lungs with respired air, or air partially deprived of oxygen. The apparatus of the French surgeon consists of a tube, a pair of bellows, and a copper vessel for heating the air prior to its introduction. The tube, fig. 309, is composed of three pieces, the two outer of which are connected together near the centre by a hinge, and are so arranged as to depress the tongue and elevate the epiglottis. The bellows, represented at fig. 310,

is double valved, and provided with a stop-cock at one end, and at the other with a graduated arc, indicating the quantity of air proper to be introduced at different ages. A moderate quantity of air having been thrown into the lungs, the chest and abdomen are compressed to expel it, and these two alternate processes are then continued as long as may be deemed necessary. In the mouth to mouth

Fig. 309.



Leroy's Tube for Inflating the Lungs.

Fig. 310.



Leroy's Bellows for Inflating the Lungs.

insufflation, the nostrils must be closed with the fingers, and the larynx well pressed back against the œsophagus, lest the air, passing into the stomach, should so distend that organ as to interfere seriously with the play of the diaphragm. Laryngotomy should only be performed in desperate cases of apnœa, in which ordinary insufflation is found to be impracticable or unavailing.

How long these efforts should be continued must depend upon circumstances. Unless the body, when taken out of the water, is perfectly cold and rigid, showing that life is irretrievably extinct, they should be steadily maintained for at least from three to four hours. A remarkable instance has been related by Mr. Douglas, in which no evidence of respiration was perceived until after the manipulations had been uninterruptedly continued for eight hours and a half.

The signs of returning animation are flushing of the countenance, warmth of the surface, slight convulsive tremors, especially of the muscles of the face, sensibility to light and noise, and gasping, sobbing, or sighing respiration. When the case is unpromising, the body remains cold, pale, or livid, there is an absence of muscular contraction, and special sensation is annihilated.

In the treatment of suspended animation from hanging, garroting, or manual strangulation, the principal means of resuscitation are exposure of the body to currents of cold air, affusion of cold water, flagellation, artificial respiration, insufflation of the lungs, the application of sinapisms to the extremities, spine, and precordial region, and the abstraction of blood from the arm or jugular vein, especially when there is unusual lividity of the countenance, indicative of cerebral and pulmonary congestion. Galvanization along the course of the spine and over the heart has occasionally been found serviceable. These efforts, as in suspended animation from drowning, should be continued for several hours, except in cases attended with dislocation or fracture of the neck, severe lesion of the larynx, or great delay in the employment of appropriate measures.

In asphyxia caused by the inhalation of noxious gases, as carbonic acid and sulphuretted hydrogen, the treatment is conducted upon the same general principles as in apparent death from drowning and strangulation by hanging. The moderate abstraction of blood will usually be called for in cases of this kind. When there is reason to believe that the cause of the apnœa is spasm of the glottis, not a moment should be lost in opening the trachea.

A curious form of asphyxia occasionally occurs in infants, while asleep, not from

being overlain, as is usually supposed, by the mother or nurse, but from being smothered by the manner in which the head is buried under the bedclothes. Similar accidents are liable to take place, in cold weather, in railway and other journeys. Death, under such circumstances, is evidently due to the small quantity of air which surrounds the victim's face, and which soon becomes unfit for respiration by the abstraction of its oxygen and the substitution of carbonic acid gas. Resuscitation should be attempted in the usual manner.

No writer, so far as my information extends, has made any mention, in connection with the resuscitation of asphyxiated persons, of what I conceive to be, next to artificial respiration, the most valuable element in the treatment of this class of affections. I allude to flagellation, or slapping of the surface, either with the bare hands, a bundle of thin switches, a lash made of thin pieces of cord, or the fringed end of a towel, used either dry, or wet with cold water, the latter mode being particularly serviceable in warm weather. I know of nothing that is so powerful an excitant of the vaso-motor system of nerves, and of the cerebro-spinal axis, as this.

Persons, after having partially recovered from asphyxia, sometimes perish from the secondary effects, as from congestion of the brain and lungs, spasm of the glottis, sheer exhaustion, or, as in drowning, from the presence of water in the air-passages. The only way to avoid such untoward occurrences is to confine the patient to his bed, to give him proper nourishment and stimulants, and to keep steady guard over him, in order that, if any unfavorable symptoms arise, they may be promptly met by suitable measures.

XVIII.—BRONCHOTOMY.

Under this denomination are included the four operations known, respectively, as laryngotomy, tracheotomy, laryngo-tracheotomy, and subhyoid-laryngotomy. These operations may be rendered necessary by the following circumstances: 1. The presence of foreign bodies in the air-passages. 2. Spasm and œdema of the glottis. 3. Ulceration, scalds, and contusions of the larynx. 4. Morbid growths. 5. Laceration of the windpipe. 6. Tonsillitis and retropharyngeal abscess. 7. Impacted matter in the œsophagus. 8. Suspended animation. 9. Carotid aneurism. 10. Membranous croup, diphtheria, erysipelas of the fauces, and smallpox of the larynx.

Laryngotomy.—Laryngotomy is a very simple and easy operation. The only structures that are divided are the skin, the cervical fascia, and the crico-thyroid membrane. If the patient is an adult, he may sit upon a chair, or, what is preferable, especially if, as is generally best, he take chloroform, lie upon a narrow table, the head and shoulders being properly elevated and horizontalized by pillows. If, on the contrary, he is a child, he may be supported upon the lap of an assistant, his body and limbs being securely fastened with an apron, very much as in the operation for harelip. The head, thrown backwards, is held by another assistant, in such a manner as to render the parts unusually prominent, and make the chin look directly forwards. An incision, embracing the skin and cervical fascia, is made along the centre of the larynx, from the top of the thyroid cartilage to the base of the cricoid, its length, in the adult, being fully one inch and a half, and hardly any less in a short, thick-necked child. The crico-thyroid artery is at once ligated, or forcibly twisted, lest the blood should find its way into the windpipe, and thus occasion severe cough, if not suffocation. The crico-thyroid membrane is divided, in its whole extent, in the direction of the cutaneous wound. If the opening thus made is not sufficiently large, the incision may be prolonged into the contiguous cartilages, or a piece of the membrane may be cut away on each side of the wound. Some surgeons prefer a crucial incision, and such a proceeding is quite proper when it is desirable to afford free play to the instruments without interfering with the thyroid and cricoid cartilages.

Tracheotomy.—If laryngotomy is simple and easy, it is far different with tracheotomy. This is particularly true of tracheotomy in children with a short, thick neck, to say nothing of the cries and struggles which they are sure to make if they are not fully chloroformed, or nearly choked to death. The use of an anæsthetic greatly facilitates the operation, and divests it of much of the dread always so justly entertained respecting it.

In tracheotomy, fig 311, the same general rules are to be observed as in laryngotomy. The patient being recumbent, with the neck well elevated and extended, an incision is made through the common integument, directly along the middle line,

extending from the base of the cricoid cartilage to within a quarter of an inch of the top of the sternum. The sterno-hyoid and sterno-thyroid muscles are next separated from each other at their raphe, by a cautious use of the handle of the knife, aided, if necessary, by the point of the instrument, when the cervical fascia and the thyroid

Fig. 311.



Operation of Tracheotomy.

plexus of veins will be fully brought into view. The former is divided in the same careful manner, while the latter is pushed aside, and protected by a blunt hook. If the middle thyroid artery is cut, which, however, is a rare contingency, it must instantly be secured. The isthmus of the thyroid gland, even when it descends unusually low, seldom occasions any serious embarrassment; when it does, it must be held out of the way, or be included in two ligatures, and divided at the middle, otherwise copious hemorrhage may ensue.

Satisfied that there is no blood at the bottom of the wound, the surgeon steadies the trachea with the left index finger, or, what is better, with a tenaculum, and divides at least three of its rings. In executing this step of the operation, the knife, entered at a right angle to the surface of the tube, with its back towards the sternum, is carried from below upwards, lest injury be inflicted upon the great vessels at the root of the neck. The incision in the trachea must strictly correspond with the centre of the external wound, and should be at least an inch in length. If shorter than this, it will scarcely suffice for the spontaneous ejection of the foreign body, or the proper play of the forceps.

Laryngo-tracheotomy.—In performing laryngotomy, it not unfrequently happens that the opening afforded by the division of the crico-thyroid membrane is inadequate for the purpose for which it was made. In this event, it may very readily be enlarged to the requisite extent, by dividing the cricoid cartilage and one or two of the upper rings of the trachea. The operation, thus performed, is denominated laryngo-tracheotomy, as denotive of the parts concerned in it. The chief objection to it is the danger of wounding the isthmus of the thyroid gland, and the branch of the superior thyroid artery which so frequently courses along its upper border. When the foreign body is so firmly impacted in the larynx as to render it impossible to remove it by the ordinary operation, the thyroid cartilage may be divided in its whole length along the middle line.

Subhyoid Laryngotomy.—This operation, originally suggested by Malgaigne, may occasionally be advantageously employed when the larynx is obstructed by a foreign body, or by a morbid growth, situated high up in the passage, or projecting into the fauces. It might also be proper in impending asphyxia caused by the presence of

an abscess in the spongy structure at the base of the epiglottis. The parts involved in the procedure are, the common integument, superficial fascia, platysma-myoid muscle, and thyro-hyoid membrane, bounded on each side by the omo-hyoid, sterno-hyoid, and thyro-hyoid muscles. A synovial burse, of variable size, exists at the middle line, beneath the fascia. The superior laryngeal artery and vein, the only vessels of any importance in this region, course along the upper border of the thyro-hyoid cartilage, and are, therefore, in no danger of being wounded. The laryngeal nerve pursues a similar direction.

The operation consists in carrying the knife horizontally along the inferior border of the hyoid bone for a distance of about one inch and three-quarters, dividing, first, the skin, fascia and platysma-myoid muscle, then the inner half of each sterno-hyoid muscle, and, lastly, the thyro-hyoid membrane, along with its mucous lining. As soon as the incisions are completed, the epiglottis, forced into the wound by the expiratory efforts of the patient, is seized with the tenaculum, and firmly held until the larynx, now fully exposed to view, has been thoroughly explored, and the object of the operation accomplished.

XIX.—INTRODUCTION OF TUBES.

The introduction of tubes into the windpipe is rendered necessary whenever that canal is opened to favor the ingress of air, in cases of mechanical obstruction. The only exception to this rule is, or should be, when the dyspnœa is occasioned by a foreign body, the expulsion of which might be prevented by such instruments.

These tubes, which are generally made of silver, should possess the qualities of lightness and of accurate adaptation to the parts which they are destined to serve. Their length varies from an inch and a half to two inches and a quarter, according to the stature of the patient, and their diameter should be such as to admit of easy introduction, without at all encroaching upon the surface of the windpipe. Their shape is cylindrical, with a slight antero-posterior curvature, the concavity of which is directed forwards. The superior extremity of the instrument is provided with two rings, for the passage of tapes, which, tied at the back of the neck, secure it firmly in its place.

A great variety of tubes, as to form and size, is before the profession. Among the more recent and valuable of these is the one devised by Mr. Durham, which is so shaped as to pass straight back into the trachea, and then turn in such a manner as to lie in the middle of the canal, without exerting any pressure upon its walls. The distal portion of the inner canula is articulated or jointed together in the lobster-tail fashion.

Most instruments of this kind are made double, as seen in fig. 312, the inner one, which is nearly a fourth of an inch longer than the outer, being so constructed as to

Fig. 312.



Trachea Tube.

admit of easy removal for the purposes of cleanliness. This is a matter of paramount importance, as the tube soon becomes clogged with thick, tough, adherent mucus, thus rendering frequent withdrawal absolutely indispensable. Meanwhile, the outer instrument, or sheath, being retained, the introduction of the inner is thereby much facilitated; so that, in fact, the operation may readily be intrusted to any intelligent nurse, or even, in some cases, to the patient himself. The two tubes are fastened together by a button. The breathing orifice should always be carefully covered with a piece of gauze, to prevent the ingress of flies and other extraneous substances.

When a tube is intended to be worn in the larynx, it will generally be necessary to remove an elliptical section of the crico-thyroid membrane, in order to afford sufficient room for its accommodation. Occasionally, the object may be attained by a large crucial incision.

The period during which such an instrument should be worn must, of course, depend upon circumstances, or, more properly speaking, upon the necessity which led to its introduction. In some instances it may be dispensed with in a very short time, while in others it may require to be retained for years, if not during the remainder of life. In acute disease, the tube should not be removed until all danger

of suffocation is passed, as the wound, in general, rapidly contracts, and might thus lead to a return of dyspnœa. Whenever the patient wishes to speak, he must place his finger upon the orifice of the instrument.

The diameter of the tube should vary according to the size of the trachea. In the adult, there is usually no difficulty in this respect. In children, it is different. Mons. Morax, who has carefully measured the trachea in children between the ages of two and fifteen years, finds that the diameter ranges from three lines to half an inch, as the minimum and maximum, at these different periods of life. Hence, he recommends a tube for a child under four years of age, of a quarter of an inch; of one-third of an inch, for a child from four to eight years; of two-fifths of an inch, from eight to twelve; and of half an inch, from twelve to fifteen. About three-fifths of an inch is the proper size for an adult, in whom the diameter of the trachea varies from five-eighths to two-thirds of an inch.

When a tube of this kind is worn for a long time, it is liable to become corroded, and, breaking, a portion may fall into the windpipe, causing suffocation, as in the cases narrated by Chelius, Spence, and others.

The first introduction of these tubes is generally attended with more or less spasmodic cough; but this soon subsides, and in a short time the parts cease to resent the intrusion. In croup and diphtheria, death has occasionally occurred from a portion of false membrane becoming entangled in the canula, as in an interesting case mentioned to me by Dr. Thomas Buckler, of Baltimore. Ulceration in the edges of the wound, and of the windpipe around the instrument, is not uncommon, and may be productive of serious consequences. Not less than three cases have been reported in which the innominate artery was laid open in this way; and a number of instances have occurred in which fatal hemorrhage arose from some of the smaller cervical vessels being perforated in the immediate vicinity of the trachea. In addition to the dangers encountered from these sources, the irritation exerted by the pressure of the instrument may give rise to violent inflammation and abscess of the neck, bronchitis, pneumonia, erysipelas, and even pyæmia.

When bronchotomy is performed for the relief of croup, diphtheria, and similar affections, the windpipe should not be sucked, with a view of promoting respiration, without the precaution of washing out the mouth and throat well, immediately after, with a strong solution of chlorinated soda, or some other disinfecting fluid, for the purpose of promptly neutralizing the poison contained in the secretions of the parts. For the want of this precaution, several valuable practitioners have recently lost their lives, while a number of others have severely suffered without fatal consequences.

CHAPTER X.

INJURIES AND DISEASES OF THE NECK.

SECT. I.—WOUNDS.

ALTHOUGH wounds of the neck are treated upon the same general principles as wounds in other parts of the body, yet they possess certain peculiarities which render it necessary to notice them separately. Of these peculiarities, the most important are hemorrhage, inflammation of the air-passages, emphysema, inanition, and the occurrence of fistule. Wounds of the larynx and trachea are treated of in the preceding chapter.

In regard to their character, wounds of the neck may be incised, contused, lacerated, punctured, or gunshot, precisely as in other regions of the body. In their extent, they vary from the merest scratch to almost complete severance of the neck, involving, of course, in the latter case, muscles, fasciæ, nerves, and vessels, along with the windpipe and œsophagus. The most frightful injuries of this description are generally inflicted in attempts at suicide, and yet, strange to say, these attempts are often entirely abortive, depending upon the fact that most persons, intent upon

self-destruction, select the upper part of the neck, in the belief that suffocation will speedily ensue simply by opening the larynx. The consequence is that, although the gash may be most horrible, yet, the large vessels and nerves escaping, the patient not unfrequently makes a good recovery.

The sources of *hemorrhage* in wounds of the neck vary according to the situation of the injury. When the knife is drawn deeply across the lower cervical region, the bleeding usually proceeds from the carotid artery and jugular vein; when the larynx is involved, the thyroid vessels generally furnish the blood, while high up, as when the lesion occupies the interval between the hyoid bone and the chin, the hemorrhage is derived from the lingual artery. It has been doubted whether the windpipe and œsophagus could be completely severed without injury of the carotid artery and jugular vein; but the possibility of the occurrence has been attested by several well authenticated cases.

The cervical portion of the internal carotid is sometimes laid open, and the hemorrhage thus occasioned may be so excessive as to prove fatal in a few seconds. The most common cause of the injury is a stab, puncture, or gunshot wound in the neck directed obliquely upwards and inwards towards the throat; or the lesion may be inflicted in the opposite direction, as when a person is shot through the face, or when he falls down with a knife, piece of wood, or tobacco-pipe in his mouth.

The hemorrhage attending wounds of the neck may be almost instantaneously fatal, especially when it proceeds from the large vessels; or, the patient fainting, a temporary stop may be put to it until the surgeon has time to apply a ligature. Not unfrequently death is occasioned by the blood flowing into the air-passages, and so causing suffocation, even, perhaps, when no important artery has been laid open, or, if laid open, after it has been tied. In wounds of the cervical veins, the patient sometimes perishes suddenly from the admission of air. A remarkable case has been related by Mr. Samuel Cooper, of a soldier who was almost instantly suffocated by the pressure of a large quantity of blood that had been effused between the integument and the trachea. The hemorrhage, caused by a gunshot wound of the internal jugular vein, was entirely subcutaneous. The ball had entered behind the mastoid process, and passed obliquely downwards and forwards towards the sternum. Sometimes, again, the event is brought about by secondary hemorrhage, at the distance of several days or even several weeks from the receipt of the injury.

A rare case of wound of the neck followed by secondary hemorrhage has been recorded by Hennen. A soldier at the battle of Waterloo was struck on the tip of the nose by a ball, which split upon the bony edge of the organ at its junction with the cartilage. A piece of the ball was extracted on the spot. The cure went on without accident until the tenth day, when suddenly violent hemorrhage appeared in the nose and mouth, causing death in a few hours. The dissection showed that a very small fragment of the missile had lodged in the sinus of the internal jugular vein, which had ulcerated and burst.

In 91 cases of wounds of the neck, involving the internal jugular vein, and made, for the most part, in the removal of morbid growths, analyzed by Dr. S. W. Gross, the vessel was tied in 43, of which only 4 terminated fatally, the cause of death in all having been secondary hemorrhage coming on about the period of the separation of the ligature. In only one of the cases was there any evidence of pyemia; in none of diffusive phlebitis. Of 23 cases, of which the treatment is not designated, all were fatal; 4 from the entrance of air, 6 from primary hemorrhage, 6 from secondary hemorrhage, 5 from pyemia, 1 from epilepsy, and 1 from softening of the brain. Of 16 cases in which compression was employed, 2 died, 1 from apoplexy, and 1 from secondary hemorrhage. In 9 cases the carotid artery—generally the common trunk—was wounded at the same time, with the result of an aneurismal varix, usually productive of little inconvenience. The average period of the separation of the ligature was 14 days, the minimum 4, and the maximum 23. Gunshot wounds of the internal jugular vein, in all the cases tabulated by Dr. Gross, were fatal, either from primary hemorrhage, secondary hemorrhage, or pyemia.

A curious case of gunshot wound of the neck is mentioned by Velpeau, in which a communication existed between the carotid artery and internal jugular vein, in the latter of which the ball was found, on dissection, fifteen days after the accident.

The treatment of hemorrhage of the neck consists in ligating the affected vessels, whether arterial or venous. As a general rule, two ligatures should be applied; on

the carotid, to prevent reflux bleeding from the distal side of the wound, and on the internal jugular vein from the cardiac side. This procedure I was compelled to adopt in 1866, in the case of a man, forty-eight years of age, in which I accidentally divided this vessel in removing a deep-seated cystic tumor of the neck. With the exception of a slight attack of erysipelas, he recovered without an untoward symptom.

When the jugular vein is merely nicked, the safest plan, if the bleeding cannot be staunched in any other way, is to surround the vessel with a ligature, instead of encircling the edges of the wound, as hitherto so generally recommended. Such a procedure is always liable to be followed, on the detachment of the ligature, by hemorrhage, from the insufficiency of the adhesions of the sides of the vessel. Besides, there is much greater risk of pyemia and diffuse phlebitis.

When the internal jugular vein is inaccessible to the ligature, the wound should be plugged with pieces of sponge or patent lint, supported by adhesive strips and a roller, the head being maintained in an easy, elevated position.

In punctured wounds of the neck involving the carotid artery, the quantity of blood effused in the connective tissue is sometimes so great as to render it difficult to find the orifice of the bleeding vessel. In such an event, the only way to effect the object is to enlarge the opening freely upon the grooved director, to turn out the clots, and then to apply the ligature in the usual manner. Hemorrhage of the cervical portion of the internal carotid requires ligation of the primitive carotid, as the injured vessel itself does not admit of direct interference. In secondary hemorrhage of the carotid, caused by sloughing or extensive suppuration, direct compression, by means of a sponge wet with a strong solution of subsulphate of iron, is sometimes the only available method of arresting the flow of blood, and saving the patient's life. The wounded artery, inflamed and disintegrated, is unable to support the ligature until an efficient clot is formed.

Wounds of the *œsophagus* and *fauces* should be treated upon the same general principles as wounds of the intestines; that is, by sutures, placed from two to three lines apart, the needle being carried close down to the mucous membrane, and the ends of the ligature, drawn very tightly, cut off very near to the knot, in order that the thread may eventually find its way into the interior of the tube. The patient is supported by the stomach tube, introduced several times a day, and also, if necessary, by nutritive enemata.

Wounds of the *cervical nerves* are always objects of deep interest. Division of the phrenic nerves is necessarily instantaneously mortal, and the same is true of division of the pneumogastric nerves, although this has occasionally been denied. If only one of the pneumogastric nerves is severed, the patient may survive, as in the cases which occurred to Labat, Dr. J. H. B. McClellan, and Billroth, or he may finally perish from the effects of congestion and inflammation of the lungs.

Wounds of the neck are sometimes followed by *paralysis* of the superior extremity, from violence inflicted upon the axillary plexus of nerves. In 1858, a young man was at the clinic of the Jefferson College, who had been struck in the neck with a long, narrow knife, the blade entering a little to the left of the median line, and passing behind the trachea and *œsophagus*, both of which, as well as the large cervical vessels, escaped injury. The right superior extremity became immediately affected with palsy, succeeded by a sense of numbness in the thumb and first two fingers, rendering it thus highly probable that the weapon had wounded the median nerve, either close to its origin, or at the axillary plexus. The muscles soon began to waste, and when I saw the case, about six weeks after the accident, the whole limb was excessively atrophied, icy cold, and of a purple color. The deltoid was very tender on pressure, and severe pain extended along the arm as far as the ends of the fingers, which hardly admitted of the slightest motion. The general health had suffered a great deal, the countenance was very pallid, and there was great disorder of the digestive organs, with loss of sleep. Such lesions, unfortunately, are usually hopelessly irremediable. In the case here described, I was induced, as the man was poor, and endured great pain, to advise amputation at the shoulder-joint, if, in the course of a few months, there should not be marked amelioration.

SECT. II.—WRYNECK OR TORTICOLLIS.

Wryneck, the torticollis of the older surgeons, consists in a permanent structural shortening of some of the cervical muscles, especially the sterno-cleido-mastoid and

Fig. 313.



Wryneck.

splenius, twisting the head over to the corresponding side, while the chin projects proportionately in the opposite direction, as seen in fig. 313, from one of my clinical cases. The distortion thus produced is characteristic, causing a disagreeable, sinister, and constrained appearance, which nothing else can imitate. When existing in a high degree, the ear is approximated to the upper extremity of the sternum, the clavicle is elevated and deformed in consequence of the excessive tension of the sterno-cleido-mastoid muscle, and the chin is thrown far beyond the middle line, almost into a horizontal position, by the inordinate contraction of the splenius and trapezius muscles. The expression of the features is remarkably altered; the face on the affected side having a withered, atrophied appearance, the corner of the mouth being depressed, and the eye being much lower than the opposite one. The head is nearly

immovably fixed, so that, if the patient wishes to look at any object, he is obliged, unless it is directly in front of him, to turn his whole body; and there is generally, in the more aggravated cases, a peculiar lateral curvature of the neck, the concavity of which presents towards the contracted side, due to the shortening of the scalene muscles.

Wryneck occurs in both sexes, but my experience has afforded a larger number of cases in females than in males, and there is no doubt that the affection is generally considerably more frequent in the former than in the latter. The lesion, which is most common in children from three to ten years of age, sometimes begins soon after birth. It has been said to be occasionally congenital, and cases of this description are no doubt now and then met with, but they must be extremely rare, none having ever fallen under my observation. The affection recognizes several distinct causes, of which the principal are inflammation, disease of the cervical vertebræ, and paralysis of the muscles. It may also be induced simply by a vicious position of the head, in consequence of the existence of an enlarged and painful condition of the lymphatic glands of the neck, compelling the patient to keep the cervical muscles in a constrained and rigid state. Any circumstance, in fact, that has a tendency to destroy the equilibrium of these muscles, and to place them in an antagonistic condition towards each other, may produce the distortion at any period of life, particularly in children during the rapid development of the body.

However induced, the affected muscles soon become permanently contracted and greatly indurated, as is rendered evident both to the touch and the knife. They feel like dense, rigid cords, which hold the head firmly in its unnatural position, and of which the outline is easily traced along the neck. They are diminished not only in length, but also in breadth and thickness; their fibres, in cases of long standing, are converted into pale, fibrous filaments, united by unyielding cellular tissue, and hence, when an attempt is made to divide them, they offer an extraordinary degree of resistance, almost creaking under the knife. These circumstances, taken in connection, afford indisputable evidence that, whatever the exciting cause of wryneck may be, the muscles concerned in its production become the seat of inflammation and plastic effusion, probably at an early period after they have lost their equilibrium, unfitting them for the resumption of their functions without the division of their fibres. In addition to these changes in the muscles, the integument, fasciæ, and ligaments are permanently shortened, and the articular surfaces of the vertebræ are often rotated upon their axes, as in lateral curvature of the spine.

The number of muscles affected in wryneck varies in different cases. Although the sterno-cleido-mastoid always suffers more than any other, yet it is by no means the only one which is concerned in producing and maintaining the distortion. The

platysma, trapezius, scalene, splenius, and even the elevator of the scapula, not unfrequently participate in the disorder. It has been found that the sternal portion of the mastoid always suffers first, but I have never seen a case of confirmed wryneck where the clavicular division was not also implicated, generally in a very marked degree.

The prognosis of wryneck depends upon circumstances. In the more simple forms of the affection, caused solely by muscular contraction, a cure may generally be certainly calculated upon, especially when the case is comparatively recent. If, on the other hand, the deformity is of a complicated character, as when it is associated with organic disease of the spine, serious lesion of the nervous system, or a crippled state of a large number of muscles, the patient may consider himself fortunate if he obtains any relief at all.

In the *treatment* of this affection, the first indication is to ascertain, if possible, the nature of the exciting cause. If it depends upon rheumatism, the diagnosis may usually be easily determined by observing that this disease exists at the same time in other parts of the body, and that the muscles of the neck are extremely painful and intolerant of motion and manipulation; more or less fever will probably be present, and the features will exhibit a wan and contracted appearance, expressive of the local and constitutional distress. If the case is seen early in the attack, bleeding by leeches will prove beneficial; the bowels should be well moved; and the system should be promptly brought under the influence of calomel and opium, followed by colchicum. Anodyne embrocations, and the application of steam, directed to the part by means of a tube, will be the most suitable local remedies. The subcutaneous injection of a minute quantity of sulphate of atropia has been attended with happy results in the hands of Dr. Da Costa, and faradization holds out excellent prospects for relief.

A careful examination will generally be sufficient to detect the presence of organic disease of the cervical vertebræ. The most important signs are, the existence of the strumous diathesis, unnatural projection of the spine, and the impossibility experienced by the patient in performing the most simple movements of the neck. The proper treatment will be the prone position, maintained for months together, and a course of alterants and tonics, with a caustic issue at the seat of the disease.

Paralysis of the sterno-cleido-mastoid muscle has been more frequently accused as a source of wryneck than it probably deserves. Very few of the cases that have fallen under my observation could be traced to such an origin. The affection usually begins insidiously, and may depend upon various causes, especially disorder of the digestive organs and of the cerebro-spinal axis. It may affect both muscles, but, in general, it is limited to one, and then the other, continuing the exercise of its functions, contracts upon itself, and is eventually converted into a dense, rigid cord, in obedience to a law that a muscle, deprived of antagonism, is gradually reduced to a kind of fibrous mass, much below the volume of the original. The diagnosis is easily established by a careful examination, which will disclose the great difference in the state of the two muscles, the excessive distortion of the features, and the atrophied condition of the face on the side corresponding with the contraction.

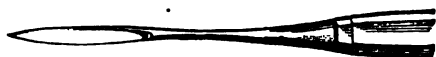
The treatment must be directed to the removal of the exciting cause; when this cannot be detected, the case must be managed upon general principles. Gentle purgation, a judicious regulation of the diet, and strict attention to the secretions, will always be beneficial, and must, therefore, not be neglected. Chalybeate tonics, the cold shower-bath, followed by dry friction with the flesh-brush, and exercise in the open air, will be required for the weak and anemic. Shampooing and electricity have been highly lauded in this form of wryneck, but their value has been greatly overrated.

When the affection has reached its confirmed stage, the only remedy is the division of the contracted muscle, and it is well to know that nothing is to be gained in such a case by delay or by a resort to extending apparatus, however ingeniously constructed, or diligently and perseveringly applied. Such a hope is perfectly futile. The subcutaneous operation possesses great advantages over the direct section practised in former times, which always exposed the patient to severe suffering and to protracted suppuration, besides generally eventuating in an imperfect cure. The modern procedure is entirely free from all such contingencies. The only objection that can be at all alleged against it is the difficulty of its execution, but this, I am satisfied, has been greatly exaggerated, for there is no educated surgeon who need

be afraid of undertaking it, provided he recalls to mind, at the time, his knowledge of the anatomy of the parts. None but the merest bungler could possibly injure the carotid artery or the internal jugular vein; and as to the external jugular, which lies immediately behind the sterno-cleido-mastoid muscle, no serious harm could result from its subcutaneous division, as the bleeding could easily be controlled by pressure.

In performing the operation, which should be done while the patient is under the effects of chloroform, the head, inclined slightly forwards, should be held as firmly as possible by an assistant, while another has charge of the extremities. The left finger

Fig. 314.



Tenotome.

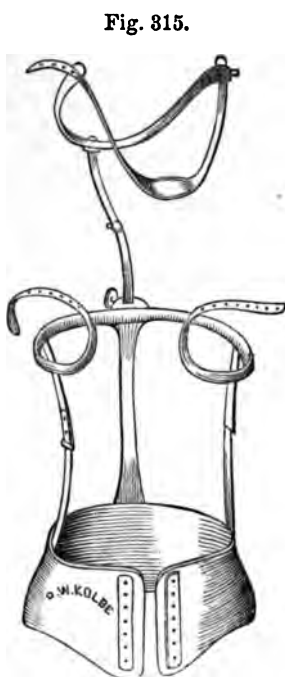
is then insinuated behind the sternal portion of the muscle, immediately above its origin, when a delicate tenotome, fig. 314, such as that used in the operation for clubfoot, is inserted flatwise behind the muscle at its outer edge, and thence carried on in close contact with its posterior surface, until its point meets the finger on the opposite side. The cutting edge being now turned forwards, the muscle is carefully divided from behind forwards by a kind of sawing motion, from nine to twelve lines above the sternum. The sudden retraction of the belly of the muscle, sometimes with a distinct noise, will denote the completion of the operation. If the clavicular portion be now found to be tense and resisting, the knife should next be passed beneath it, and its division effected in the same cautious manner. Bands of the cervical aponeurosis occasionally project, and may be

severed with a narrow, blunt-pointed bistoury, having only about a line of cutting edge near its extremity. If the border of the trapezius is at fault, it may now be divided, and so also any other muscle, provided its proximity to the great cervical vessels and nerves does not absolutely forbid interference.

The above procedure is one which I have always adopted, and in no instance has it been attended by any casualty. The fact is, it is a very simple operation, and one entirely free from danger.

The puncture made with the tenotome is closed with a bit of adhesive plaster, and the patient is placed in bed with his head in a relaxed and easy position. Light diet is enjoined, and a mild purgative may be given the morning after the operation. As soon as he is able to get up, which will usually be in four or five days, the head should be supported with a suitable apparatus, so constructed as to produce gradual extension of the affected side of the neck. Various contrivances of this kind may be obtained of any of the more respectable cutlers, all of them possessing more or less merit, and well calculated, if judiciously applied, to effect a cure, although not without protracted perseverance.

The annexed drawing, fig. 315, exhibits the apparatus of Mr. Kolbé, one of the best of the kind yet devised. It consists of a leather corset for the pelvis, and a lever for the head, with a strap to support the chin, connected by a steel rod, which is moved by a ratchet-wheel, turned by a key, the whole arrangement being such as to permit



Kolbé's Apparatus for Torticollis.

the head to be inclined to one side or the other at pleasure. The cure is promoted by daily frictions with stimulating liniments. Sometimes I dispense with the use of apparatus altogether.

SECT. III.—PARALYSIS OF THE CERVICAL MUSCLES.

Under this denomination may be described a very singular affection of the muscles of the neck, consisting in an irregular spasmodic contraction of their fibres, attended with a helpless condition of the head. The true pathology of the disease seems to be palsy of some of the cervical muscles, which disqualifies them for sup-

porting the superincumbent weight. In some of its features, it closely resembles chorea, but it differs from this complaint in being of more limited extent, and unaccompanied by any disorder of the mental faculties. In some instances, the affected muscles undergo a species of atrophy, similar to what occurs in wasting palsy. All the cases—probably about a dozen—that I have seen of it occurred in persons after the age of thirty, and of these the majority were females of a nervous, hysterical temperament. It occasionally begins at an early period of life.

The affection generally commences without any assignable cause, and gradually progresses, from bad to worse, until at length the patient is often unable to support his head, or to exercise any control whatever over its movements. In nearly all the cases under my observation, it was subject to temporary aggravation, apparently consequent upon disorder of the digestive apparatus, irregularity of the menses, or derangement of the nervous system, especially the presence of spinal irritation. Sometimes the muscles are quiescent for days together, when, perhaps all of a sudden, they begin to twitch and jerk, until the patient is nearly exhausted with fatigue. Most commonly the head is drawn to one side, evidently by the inordinate action of the sterno-cleido-mastoid, which is thrown into a tense cord that no force can relax. At other times it is thrust powerfully backwards, the neck forming an arched appearance, very much as in opisthotonos. When the affection is fully established, the patient is obliged to support his head almost incessantly with his hand. One of my patients is in the habit of controlling the spasms with the index finger gently pressed against the chin or side of the jaw. It is seldom that the head is inclined directly forwards against the sternum.

The general health is usually materially impaired; the digestive powers are weakened, the bowels are constipated, and the patient is easily fatigued on taking exercise. The extremities are nearly always cold. Great difficulty is sometimes experienced in mastication and deglutition. The mind preserves its natural vigor. Disorder of the menstrual function is often present. Occasionally the affection coexists with similar suffering in other parts of the body.

The diagnosis is readily determined by the history of the case, and by the peculiar character of the spasm. In most of the cases that I have seen, the muscles of the neck, both superficial and deep, seemed to be involved nearly in an equal degree.

The prognosis is unfavorable. Temporary relief may generally be afforded, but a permanent cure is very uncommon; and, on the other hand, I have never witnessed a case that proved fatal from this cause alone.

The treatment must be mainly by tonics, alterants, and purgatives. The secretions must be well looked after. In the female, benefit may be expected from the use of emmenagogues, valerian, assafoetida, and iron with bark. Electricity, medicated frictions, the cold shower-bath, hypodermic injections of morphia or atropia, and exercise in the open air, often afford temporary relief. Subcutaneous division of the contracted muscles is sometimes advantageous, but seldom to the extent that might be anticipated by one who has no experience in the treatment of this disease. I have performed tenotomy most extensively in some of these cases, with no ulterior advantage in any, except one, and in that the relief was perfect and permanent. When the affection is irremediable, the sufferer will be benefited by artificial support, such as may readily be supplied by any ingenious cutler. In an instance recently under my observation, the good effect of this treatment was most marked.

SECT. IV.—DISEASES OF THE THYROID GLAND.

The thyroid gland is subject to various diseases, of which abscess, cysts, and hypertrophy are the most frequent and important. The heterologous formations rarely affect this organ.

1. *Abscess*.—Abscess of the thyroid gland is very uncommon; it is attended by the usual symptoms, and may, when neglected, acquire a large bulk, hanging down the neck like a big pouch. In its earlier stages, it is not always easy, or even possible, to form a correct idea of the nature of the disease; but when the quantity of matter is considerable, its presence will be indicated by a sense of fluctuation, by pain and difficulty of breathing, and by a swollen, discolored, and œdematous state of the integument. These symptoms, conjoined with the history of the case, and the concomitant febrile excitement, are quite sufficient, in every instance, to establish the diagnosis. The matter, bound down by the cervical fasciæ and muscles, is often

long in reaching the surface, to say nothing of its tendency to extend down the neck, and its escape should, therefore, always be encouraged by an early incision in the lower part of the swelling.

Such an abscess is sometimes of a latent character, as in a case which I attended, along with Dr. Charles Woodward, in a man, forty-four years of age, who died of pneumonia, after an illness of three weeks. On inspection, we found the whole of the thyroid gland, with the exception of a small portion of its inferior extremity, converted into a thin, delicate sac, containing nearly ten ounces of thick, yellowish pus, free from odor. The thyroid cartilage was completely denuded, and the matter had burrowed upwards, underneath the hyoid bone, on the left side, as far as the root of the tongue. No symptoms whatever, indicative of disease of the thyroid gland, had existed during life. The abscess was evidently of a strumous character.

2. *Goitre or Bronchocele*.—Goitre, technically termed bronchocele, is a chronic enlargement of the thyroid gland. The affection, which is much more common in women than in men, and in children than in adults, not unfrequently exists as an endemic, especially in the valleys of the Alps, Apennines, and Pyrenees. In this country it is often observed in the mountainous regions of Vermont, New Hampshire, Connecticut, New York, Virginia, and Pennsylvania. In our Southern States it is uncommon. It has occasionally been noticed among our aborigines, but not to any extent. I have never seen an instance of it in the negro; but Dr. James El. Reeves, of Wheeling, informs me that he has met with it repeatedly among colored people, especially the mulatto, in West Virginia. In England, it is most common in Derbyshire, Norfolk, and Surrey. The disease is very prevalent in India, so much so that in certain districts one person out of every ten is affected with it. In the valleys and gorges of the Alps, it is frequently associated with cretinism. The afflicted being has a short, stunted body, shrivelled limbs, a large, unseemly head, a vacant countenance, and a depraved intellect. In many cases, in fact, he is idiotic.

The cause of bronchocele is evidently closely connected with the locality in which the disease occurs. Low and moist situations are most obnoxious to it, while high and airy regions are comparatively exempt. Confined, ill-ventilated localities, affected with frequent inundations, are remarkably favorable to its production. It is probable that the habitual use of water, strongly impregnated with calcareous matter, is a powerfully predisposing cause. Goitre seldom makes its appearance, even in countries where it is indigenous, before the tenth or twelfth year. Occasionally it is hereditary, and it not unfrequently occurs in several members of the same family. It has been observed in the horse, cow, sheep, dog, and other inferior animals.

The tumor varies in size, from the slightest increase of the natural volume of the gland, to that of a fist, a cocoa-nut, or an adult head. When of the latter dimensions, it may reach as high up as the ears, backwards as far as the trapezius muscles, and downwards over the sternum, forming a most disgusting and shocking mass. Both lobes are usually affected, although seldom in an equal degree. Sometimes the disease is confined exclusively to the isthmus, or to this part and to one of the lateral lobes, and cases occur in which it is of a conical form, with a small, narrow

pedicle. The swelling increases very slowly, and often remains stationary for years together. Its surface may be smooth and uniform, or rough and lobulated. A very common accompaniment is an enlargement of the subcutaneous veins. No pain attends goitre, except what results from its pressure on the neighboring structures; the skin is free from discoloration, and the general health is unimpaired. When the tumor is of unusual bulk, there may be difficulty of breathing, headache, vertigo, noises in the ears, and an altered state of the voice, which often becomes hoarse and croaking. In such cases the trachea is more or less flattened, elliptical, or even triangular, from the pressure of the superincumbent mass. The external characters of goitre are well exhibited in fig. 316, from a preparation in the Mütter collection.

Fig. 316.



Goitre or Bronchocele.

The internal structure of the tumor is liable to considerable variety, depending upon its age and progress. When of moderate standing, it is generally of a soft, gelatinous consistence, emitting, on pressure, a ropy, glutinous fluid. In more ancient cases it is of a pale cinnamon tint, hard to the feel, and interspersed with numerous cysts, due to mucous softening of the parenchyma of the gland, generally not larger than a pea, containing a serous, glairy, or melicerous substance, and occasionally pus, fibrin, or even pure blood. Fig. 317, taken from one of my specimens, exhibits this form of degeneration, the alveoli being occupied by a white, semiconcrete, waxy, amyloid substance. Calcareous concretions are sometimes found, either alone or in union with cartilaginous and osseous productions. In a small goitrous tumor now in my private collection, obtained from a man fifty years of age, there are several small, steatomatous masses, with a circular nodule of bone, about six lines in diameter. It is of a yellowish color, very compact in texture, and surrounded by a thin, imperfect capsule. Occasionally the whole organ is transformed into an osseous cyst, filled with various kinds of matter, especially the jelly-like, amyloid, and meliceric. In a specimen of this kind in my cabinet, one of

Fig. 317.



Cystic Degeneration of the Thyroid Gland.

Fig. 318.



Ossified Thyroid Gland.

the lobes has almost entirely disappeared, while the other, fig. 318, which does not exceed the volume of a hen's egg, is converted into a thick, firm, solid capsule, as hard as bone, and occupied by a white, curdy, friable substance, not unlike semi-concrete cheese.

In what is known as *cystic goitre*, the organ is the seat of one or more cysts, due to the enlargement of the normal gland vesicles, and similar to those of the liver, brain, ovaries, and other structures. Varying in number, in different cases, from one to several dozens, they are situated either directly in front of the neck, or at one side of the middle line, and are found of all sizes, from that of a cherry-stone to that of an egg. They are composed of thin, elastic coats, and are occupied by a watery, yellowish, or oily-looking fluid, coagulable by heat, alcohol, and acids, thus showing its albuminous constitution. The development of these tumors is, in general, very tardy; they are free from pain and discoloration of the integument, and they communicate to the finger a soft, elastic sensation, which readily distinguishes them from solid tumors in the same situation. The disease is rarely met with under the age of twenty-five or thirty.

In cystic disease of the thyroid gland the accumulation of fluid may reach as high as fifteen, twenty, or even thirty ounces. Generally of a serous, but occasionally of a turbid, dirty, or sero-sanguinolent character, it is usually contained in a single cyst, although sometimes the cyst is multiple, compound, or proliferous. The enlargement is commonly slow and painless; but as it increases it compresses the windpipe and œsophagus, and may thus give rise to more or less embarrassment in respiration and deglutition, both tubes being occasionally considerably flattened and contracted by the steady and persistent pressure of the swelling, as in some remarkable cases recorded by Gooch and other writers. The diagnosis is easily established by the history of the case, by the presence of fluctuation, and by the fact that the tumor ascends with the larynx when the patient swallows. If any doubt exists, it will readily be dispelled by the insertion of an exploring needle.

Under the microscope every goitre in its early stage, before it has undergone any of the transformations above described, is found to be of the nature of adenoma or

cystic adenoma, due to hyperplasia of the cellular elements of the normal gland vesicles, the majority of which contain, in addition to the follicular cells, a clear albuminous fluid. The connective tissue is only slightly involved in the enlargement, but, in what is known as fibrous goitre, ordinarily mistaken for scirrhus, it is greatly increased in quantity and indurated.

The *diagnosis* of goitre is sufficiently easy. Its early appearance, its tardy progress, its situation in front of the neck, its indolent character, and its ascent with the larynx and trachea in deglutition, leave little room for doubt in any case. The diseases with which it may be confounded are aneurism of the carotid artery, varix of the internal jugular vein, cystic tumors, and swelling of the lymphatic glands.

When goitre is excessive, and occupies the side of the neck, a part of it will necessarily project over the carotid artery, and thus receive its pulsation. In this manner the disease might easily enough be mistaken for aneurism. The signs of distinction are, the slow and indolent nature of the swelling, the absence of bellows-sound, and the facility with which the morbid mass may, in most instances, be pressed away from the cervical vessels, when the head is bent forwards so as to relax the muscles of the neck.

An instance now and then occurs in which the whole tumor is the seat of a violent pulsation imparted to it by the action of the carotid and enlarged thyroid arteries, in consequence of an anemic state of the system. The nature of the lesion is readily detected by the appearance of the patient and by the history of the case.

Varix of the internal jugular vein is uncommon. The enlargement is seated low down in the neck, immediately above the sternum, and forms a tumor of an oblong shape, about the size of an egg, soft, elastic, and compressible. It is of a bluish color, has a tremulous, pulsatory motion, and is diminished, or temporarily effaced, by pressure upon the distal portion of the vessel.

A cystic tumor, situated directly over the thyroid gland, may simulate goitre. Seldom exceeding the volume of a walnut, it is free from pain, partially translucent, soft, elastic, and obedient to the motions of the windpipe. When the diagnosis is at all equivocal, recourse is had to the exploring needle.

A scrofulous lymphatic gland, occupying the site of the thyroid body, may prove to be a source of error. The history, however, of its origin and progress, the hardness of the swelling and its tendency to suppurate, the presence of the strumous diathesis, and the existence of similar enlargements in the neighboring parts, will always be sufficient to enable the surgeon to distinguish between the two affections.

Treatment.—The treatment of goitre is generally conducted too much upon empirical principles. Hence, failure is too commonly the rule; success the exception. At the present day, reliance is mainly placed upon iodine and its various combinations, in conjunction with the use of leeches, blisters, and purgatives. It must be obvious that no remedies, however valuable in themselves, or however judiciously and faithfully employed, can avail in every instance. When the tumor is of long standing, when it has attained a large bulk, and, above all, when it has undergone some organic transformation, no mode of treatment whatever will be likely to make the slightest impression upon it. Such cases are literally hopeless. It is only in the milder forms of the disease, and in its earlier stages, that any decided benefit is to be looked for. Of the spontaneous disappearance of goitre, spoken of by some authors, I have never witnessed any examples.

My plan in this disease, for many years, has been to subject the patient to a kind of preliminary treatment, consisting of light diet, and gentle, but steady, purgation. When plethora is present, a full bleeding may advantageously be premised. After the lapse of ten or twelve days, the use of iodine may be commenced, either in substance, or in the form of Lugol's solution. The tincture I rarely employ, as it is apt to prove irritating. In whatever form iodine be administered, it is best always to combine with it a small quantity of opium or hyoscyamus; the dose should be graduated according to the age and susceptibility of the patient, and the effects of the remedy should be carefully watched. After it has been taken for a fortnight or three weeks, its use should be suspended for several days, when it may be resumed and continued as before. In some instances, the protiodide of mercury exercises a very beneficial influence, especially if carried to the extent of slight ptyalism. This article is particularly serviceable in recent cases, in which the

swelling mainly depends upon interstitial deposits. The bowels are not to be neglected. Much purging, however, is neither necessary nor proper. The diet should be vegetable and farinaceous. Change of residence is frequently indispensable, especially when the individual lives in a country in which the disease is endemic.

The topical treatment consists of the innunction of iodine, leeching, and blistering. The detraction of blood from the affected part is almost always beneficial, from its tendency to unload the capillary vessels, and to rouse the action of the absorbents. From ten to a dozen leeches may be applied every six to eight days, directly over the swelling, and the bleeding encouraged by fomentations. In some instances, a rapid reduction of the tumor is effected under the use of blisters, repeated once a week. But I have found no local remedies so efficacious as a combination of equal parts of iodine and camphorated mercurial ointment, rubbed thoroughly upon the tumor twice a day. A piece of oiled silk is worn next the skin, and over this, in cold weather, a piece of flannel, for the double purpose of preventing the unguent from soiling the dress, and keeping the neck sufficiently warm. In India, where goitre is extremely common, the ointment of biniodide of mercury has been found the most reliable remedy; and I can bear ample testimony to its efficacy from personal observation. In whatever form iodine is applied, it should not be so strong as to fret and irritate the skin, otherwise inflammation, and not absorption, will be the result.

The hypodermic injection of tincture of iodine, diluted with six, eight, or ten parts of alcohol, has occasionally been found serviceable in the milder forms of goitre. The quantity of fluid thrown in at one time should, at first, not exceed five drops, from which it may be gradually increased to ten, fifteen, or even twenty, according to the tolerance of the affected structures, a new site being selected at each operation, repeated every third, fourth, or fifth day, the effects being carefully watched.

Starvation of the tumor, by tying the thyroid arteries, has been practised, but without any encouraging results. The operation was first executed by Mr. Blizzard, of London, and since then it has been done by Walther, of Germany, Dr. Jameson, of Baltimore, and several other surgeons. In some of these cases no inconvenience ensued, and the bronchocele, in a short time, became considerably reduced in size; in others, no visible effect of any kind was produced; while in a third class the patient either died of hemorrhage or of inflammation. Whether the diminution of volume was permanent, in any instance, remains undetermined. The probability, however, is that it was not; for such is the amount of blood which the tumor receives, and so great the number of anastomosing vessels, that its proper circulation would, no doubt, be speedily reestablished.

When the tumor resists our curative efforts, and endangers suffocation, it has been proposed to afford relief by *extirpation*. But the question arises, is such a procedure proper or justifiable? In a word, can a thyroid gland, when in a state of enlargement, be removed with a reasonable hope of saving the patient? Experience emphatically answers no. This conclusion is not at all invalidated by the fact that the operation has, in a few instances, been performed successfully. It only proves that such an undertaking may occasionally be accomplished under circumstances apparently the most desperate. What has once been effected may be effected again. But no sensible man will, on slight considerations, attempt to extirpate a goitrous thyroid gland. If a surgeon should be so adventurous, or fool-hardy, as to undertake the enterprise, I shall not envy him his feelings, while engaged in the performance of it, or after he has completed it, should he be so fortunate as to do this. Every step he takes will be environed with difficulty, every stroke of his knife will, if he is not perfectly self-possessed and most cautious, be followed by a torrent of blood, and lucky will it be for him if his victim live long enough to enable him to finish his dissection. Should the patient survive the immediate effects of the operation, if thus it may be called, death will almost be certain to overtake him from secondary hemorrhage, or from inflammation of the cervical vessels, œsophagus, and respiratory organs. When the tumor is large, the wound is of frightful extent, involving all the most important and delicate structures of the neck, and rendering it altogether improbable, from the constant motion of the windpipe and œsophagus, that much of it will unite by the first intention. Thus, whether the operation be viewed in relation merely to the difficulties which must necessarily attend its execution, or

with reference to the severity of the subsequent inflammation, it is equally deserving of discouragement, if not positive rebuke and condemnation.

The great obstacle to the employment of the knife in goitre has been the fear of hemorrhage and shock, in the first instance, and afterwards, if the patient survive the immediate effects of the operation, the danger of inflammation of the air-passages from the exposure of the larynx and trachea by so large a wound of the neck. Most of the cases of excision that occurred in the hands of the older surgeons perished from the first of these causes, either before the completion of the dissection, or shortly after from exhaustion. To this category belong the examples referred to in the writings of Bonetus, Severinus, Palfin, Gooch, Bell, and Desault. Dupuytren appears to have been the first to perform an operation of this kind upon strictly scientific principles, the plan which he pursued consisting in the ligation of the thyroid arteries prior to their division, as a means of preventing hemorrhage; but, although he removed a very large tumor in this way with the loss of only a few ounces of blood, the woman never recovered from the shock of the operation, and expired within thirty-five hours after. Roux lost a case under similar circumstances. Occasionally an operation of this kind is successful. Thus, as related by Foderé, Giraudi, an adventurous surgeon of Marseilles, saved two patients by it. Desault dissected out the right portion of an enlarged thyroid gland from a woman, who recovered without any bad symptoms. In 1807, Dr. Charles Harris, of New York, successfully extirpated from a lady a large goitre, of twenty-two years' growth, extending from the chin, which it buoyed up, to one inch below the top of the sternum, and far outwards, on each side of the neck, beyond the ears. The mass, being exposed by a long incision along the middle line, was gradually enucleated with the knife and fingers, and then separated from its deep muscular attachments, as well as from the trachea and hyoid bone, a stout ligature having previously been thrown firmly around the ligamentous bands which connected it to the latter, lest it might contain important vessels which, if divided, would occasion serious hemorrhage. Only two small arteries were tied. The wound was closed with five interrupted sutures, and in three weeks the patient was well.

In 1871, Professor Green, of Portland, reported three cases of successful extirpation of goitrous tumors, two of which were of large size, the weight of one being, as was supposed, five pounds, and of the other upwards of one pound and a half. His first patient recovered without an untoward symptom, the second suffered severely for a short time from traumatic fever, and the third was seized, on the tenth day, with secondary hemorrhage, which, however, was easily controlled by digital compression, maintained for seventy-two hours. In one of the cases the œsophagus was strongly adherent to the morbid growth, and in another a distinct thrill and bruit existed, simulating aneurism. In these operations a single longitudinal incision was carried along the middle line from the chin to the sternum; the thin fibrous capsule, always present in such formations, was carefully divided upon the grooved director, and the mass was completely separated by enucleation with the finger and handle of the scalpel. No attention was paid to hemorrhage until the pedicle, with its nutrient arteries, two or three in number, was reached, which was then included in a double ligature, and severed close to its connections with the morbid growth, the blunt, curved needle used for the purpose being carried from below upwards. It is an interesting fact that the superficial vessels of the neck in all these cases were greatly enlarged, and so excessively brittle as to give way under the slightest pressure and traction.

Although the cases of Dr. Green prove that even a large tumor of this kind may occasionally be safely removed, I am clearly of the opinion that no operation should be attempted, except where the patient is in immediate danger of suffocation, when the growth has a very broad base with deep and extensive attachments, and is pervaded by large arterial and venous trunks. The risk, on the contrary, will be much less when, as occasionally happens, the tumor is pendulous and pedunculated, as in an instance under the care of the late Professor Blackman, in which a growth of this kind, after division of the integument, was completely isolated with the fingers and handle of the scalpel, with but trifling hemorrhage, until its base was reached, when the whole mass was suddenly wrenched from its connections. The excessive bleeding which followed this step of the operation was speedily arrested by means of two sponges, placed upon each other in the deep wound beneath the flaps of skin, which were fastened over them with twisted sutures. One of the sponges was

removed at the end of the sixth, and the other on the eleventh, day, the fetid odor having in the mean time been corrected by carbolic acid. The parts healed with but little suppuration, and the woman left the hospital in less than a month after the operation.

Although in this case the bleeding consequent upon the forcible evulsion of the tumor was easily staunched, it would be much safer, as a general principle, to remove the pedicle with the *écraseur*; or, if such an instrument is not at hand, to throw a stout ligature around the footstalk prior to its separation, as either procedure would thus effectually prevent hemorrhage.

Finally, when the case is utterly hopeless, and life is threatened by suffocation, temporary relief may occasionally be afforded by the subcutaneous division of the cervical aponeuroses and muscles, at the seat of the greatest constriction, thereby removing tension and pressure from the respiratory passages.

For the cure of cystic goitre six methods of treatment are at the command of the surgeon, the seton, puncture, injections of iodine, incision, excision, and electrolysis; all more or less serviceable, but not one entirely free from danger.

The seton, originally recommended by Celsus, and reintroduced into practice, in 1824, by Dr. Quadri, of Naples, acts upon the same principle as in the treatment of hydrocele of the vaginal tunic of the testicle. It should be inserted with great care, and the resulting inflammation should be sedulously watched, lest overaction arise, imperilling life, removal being effected the moment the parts become tender and painful. The danger will be greatly lessened, if, when the swelling is of great size, the fluid be withdrawn eight or ten days prior to the introduction of the seton, so as to diminish materially the area of the secreting surface. The operation has occasionally been followed by fatal hemorrhage, and a number of patients have perished from the violence of the local inflammation, from pyemia, or from a low form of fever.

Mere tapping of a cystic goitre is not always free from danger. Curling mentions a case in which a large tumor of this kind rapidly increased in size after the operation, and caused death suddenly from rupture of the cyst and the discharge of its contents into the pharynx and larynx. A similar accident occurred in a case recorded by Gooch.

Incision of the morbid mass is occasionally practised, and cases have been reported in which the operation was followed by marked diminution. The procedure is mainly adapted to tumors composed of large cysts, and the chances of success will be much increased if it be combined with the mopping of the affected cavities with iodine and the use of a tent to provoke suppuration and granulation. Great care must be exercised, otherwise the free use of the knife will be attended with copious hemorrhage.

Dr. Beck, of Freiburg, in 1836, reported three cases of excision of cystic goitre, of which two, after great suffering, recovered, while the other perished from pyemia. Dr. F. F. Maury, of this city, within the past two years, has removed the thyroid gland on two occasions for cystic enlargement. One of his patients made a rapid recovery, while the second was seized with pneumonia, from which she died on the sixteenth day. In both instances the loss of blood was insignificant, each thyroid artery being ligated near the tumor as it was exposed. In his first case the enlarged gland was peeled away from the windpipe to the extent of three inches and a half, with extensive exposure of the sheath of the carotids.

Injections of iodine occasionally succeed; but the operation is liable to be followed by severe inflammation, eventuating in rapid reaccumulation, and is, in the main, less certain than the use of the seton. When the cyst is very large, previous tapping will be advantageous. From one to two drachms of equal parts of iodine and alcohol will be a suitable quantity of fluid. If the water reaccumulates, it must be let out by an early and free incision, and no effort must be spared to keep the inflammation within proper limits.

Electrolysis has been successfully employed in some cases of this affection; but the treatment is tedious and painful, and, withal, so uncertain that few practitioners will be likely to give it a fair trial. A Daniell's battery may be used, as directed in the section on Minor Surgery; or a needle connected with the negative pole of an Althaus permanent battery may be inserted into the tumor, the circuit being closed by placing a moistened sponge, connected with the positive pole, upon the neck. The current may be maintained, at first, for a few minutes, and afterwards for a

longer time, the application being repeated, on an average, once a week. A good deal of swelling generally succeeds, but when this subsides the gland is found to be smaller than it was before. The patient will commonly require an anæsthetic during the operation.

There is a form of this affection, generally known as *exophthalmic goitre*, pulsating goitre, or Graves's disease, from the fact that it was first accurately described by Dr. Graves, of Dublin, the chief peculiarities of which are, enlargement of the thyroid body, prominence of the eyeballs, and functional disturbance of the heart, as manifested by various kinds of murmurs, and the increased force and frequency of its pulsations. It is usually associated with anemia and chlorosis, and is most common in young women of a nervous, irritable temperament. Of fifty cases analyzed by Witherisen, only eight occurred in males. The most remarkable feature of the complaint is the protrusion of the eyeballs, which is sometimes so great as to interfere materially with the closure of the lids, although it is not productive of pain, impairment of vision, or disorder of the globes. The enlargement of the thyroid body is generally most conspicuous on the right side, and rarely attains any great bulk, so often witnessed in common goitre. The malady, the pathology of which is still undetermined, is essentially chronic. The heart is seldom organically affected. The thyroid and carotid arteries beat with extraordinary vigor; and various murmurs, arterial and venous, loud, and often musical, are discernible upon applying the ear to the enlarged gland.

The most appropriate remedies are tonics, as iron and quinine, a generous diet, rest of mind and body, change of air and scene, and, in short, whatever has a tendency to invigorate the system. Hygienic measures are generally of the greatest importance. Little, if any, benefit is to be expected from local treatment.

3. *Malignant Disease*.—I am not aware that colloid or scirrhus has ever been noticed in this gland; occasionally, however, it is the seat of encephaloid and melanosis. The deposits sometimes exist as primary affections, but more generally they show themselves in connection with carcinoma in other parts of the body, as the liver, mamma, testis, alimentary canal, uterus, or lymphatic glands. In the former case, the malady is most common after the age of forty, and usually exhibits itself in the form of small nodules, dispersed through the substance of the gland, which often retains its integrity in the midst of the heterologous matter. At other times, it is seriously changed in its character, the organ itself being enlarged and deformed. The diagnosis of these affections is generally obscure, and hence they often prove fatal before an opportunity is afforded for ascertaining their real nature. Their presence may usually be suspected when the thyroid gland, in advanced life, is the seat of sharp, lancinating pains, when the affected part steadily augments in size and consistence, when the skin becomes adherent and discolored, and when there is great progressive emaciation, with hectic irritation, a sallow, sickly expression of the countenance, and the existence of malignant deposits in other organs. Encephaloid here, as elsewhere, always proceeds with great rapidity; the tumor soon acquires a large bulk, there is commonly great enlargement of the subcutaneous veins, and the general health is early and severely affected. In melanosis, which is still more rare than encephaloid, the tumor is seated just beneath the skin; and occasionally imparts its peculiar color to it. Nothing is to be expected from medicinal means in these diseases, any more than in similar affections in other parts; and, as to extirpation, I know of no circumstances that would render it advisable.

SECT. V.—TUMORS OF THE NECK.

Various tumors, mostly of an innocent character, are liable to form in front and at the side of the neck, and are often very embarrassing in their diagnosis and treatment. Among the more common of these growths are the lymphatic and the cystic, the latter of which are not unfrequently congenital.

1. *Lymphatic Tumors*.—The most common benign tumors of the neck are the lymphoid, or glandular, caused by hypertrophy of the absorbent glands so abundantly found in this region. They consist essentially of hyperplasia of the cells of the lymph follicles, which, consequently, become much enlarged, while the corpuscles of the supporting connective tissue proliferate and assume the features of lymph cells. In lymphosarcoma, on the other hand, with which these tumors, particularly the medullary forms, are often confounded, the cells of the interstitial connective

tissue are converted into spindle or small, round cells with large nuclei, which by their progressive multiplication cause atrophy of the lymph follicles.

The enlargement, dependent upon the strumous diathesis, derangement of the general health, exposure to cold, or disease of the gums, teeth, jaws, throat, or wind-pipe, may be limited to a single gland, but this is uncommon; in general, it affects a considerable number of these bodies, and cases are met with in which it involves the entire chain stretched along the edges and posterior surface of the sterno-cleido-mastoid muscle. When the enlargement is very great, and implicates both sides of the neck, it occasions the most hideous deformity, giving rise to that peculiar appearance of the neck to which, from its resemblance to the neck of the swine, the term *scrofulous* is usually applied.

Persons affected with this complaint often labor under leucocythemia, or, in other words, under a remarkable increase of the white corpuscles of the blood; they have a pale, anemic look, with a pasty state of the countenance; their digestive organs are out of order, the extremities are habitually cold, and the vital powers are at a low ebb. Chronic enlargement of the spleen is a frequent, but not an invariable, concomitant. Whether leucocythemia is the cause of the disease, or simply one of its effects, is still a mooted question.

The glandular tumor of the neck is generally tardy in its progress, and, in great measure, if not wholly, free from pain. It is of a firm, dense consistence, with a slight degree of elasticity, and is usually remarkable for its irregular, lobulated surface, the individual glands of which it is composed being either closely grouped together, or separated by distinct intervals. When the disease upon which the hypertrophy depends is extensive, it commonly involves most of the deep as well as the superficial glands, extending, perhaps, on the one hand, from the parotid gland down to the collar bone, or even beneath it, and, on the other, from the margin of the trapezius muscle behind to the larynx and trachea in front. In this way the tumor may include in its substance not only most of the muscles of the neck but also the great vessels and nerves, in one confused and inextricable mass.

When the tumor is of long standing the component glands are generally completely altered in their structure, being of a dense, firm consistence, and of a whitish, drab, or pale straw color; their capsules are thickened and indurated, and the interstitial connective tissue is either of a fibroid character, constituting the so-called fibrous tumor, or thoroughly infiltrated with cellular elements.

The diagnosis of this disease is to be deduced, first, from the history of the case, especially the nature of the exciting cause and the existence of the strumous diathesis; secondly, the tardy progress of the enlargement; and, thirdly, the tuberculated character of the morbid growth, the mass feeling as if it were composed of numerous bodies, more or less closely adherent to each other. The only malady with which it is liable to be confounded is encephaloid, but from this it may generally be readily distinguished by the facts just mentioned, by the presence of the scrofulous dyscrasia, and by the slower march of the enlargement. Moreover, in encephaloid the tumor is usually more circumscribed than in ordinary glandular hypertrophy. Another valuable diagnostic is that, in the latter affection, some of the lymphatic glands not unfrequently take on suppurative action, which is not the case in encephaloid.

In the treatment of lymphoma the surgeon must be governed very much by the nature of the exciting cause, the condition of the general health, and the progress and duration of the disease. The milder cases often promptly yield to the influence of antiphlogistics and sorbefacients, aided, when there is evidence of the tubercular dyscrasia, by the different preparations of iodine, barium, mercury, and cod-liver oil. If leucocythemia exists, immense benefit will result from the use of quinine and iron, especially the tincture of the chloride, milk punch, and change of air. When the disease is very obstinate or intractable, the knife may be necessary, but it is well to know that the operation may not only be extremely difficult, tedious, and bloody, but that it is generally fraught with danger, and that loss of life will almost be inevitable when the tumor involves the deep-seated structures of the neck, the most frequent sources of death being shock, hemorrhage, erysipelas, and pyemia.

2. *Bursal Tumors*.—An encysted tumor sometimes forms in the upper and fore-part of the neck, taking its rise in the synovial sac, situated between the hyoid bone and the notch of the thyroid cartilage. This sac, which, in its natural state, is hardly a few lines in diameter, may, in consequence of inflammation, acquire the

volume of an egg, if not of a small orange. It is of an oblong shape, elastic, slightly translucent, and filled with a thin, serous, oily, or viscid fluid. The superincumbent skin is healthy, and the swelling is entirely free from pain. A tumor of a similar nature may form in connection with the burse which occasionally exists between the integument and the thyroid cartilage. The diagnosis is determined, if need be, by the exploring needle. The treatment is by seton, injection, or incision, as in cystic tumors in other parts of the body.

3. *Sebaceous Tumors*.—Occasionally a sebaceous tumor forms in the thyro-hyoid region, where it may be productive of serious deformity and other annoyance. The most remarkable example of the kind I have ever seen came under my observation in 1841, in a lady twenty-eight years old. The tumor had made its appearance at an early age, and had attained the size of a large orange, without causing any pain or discoloration of the skin. Slightly movable from side to side, it extended upwards nearly as far as the chin, while below it overlapped the thyroid and cricoid cartilages. The operation was not difficult, and the patient made a rapid recovery. No vessels required to be tied. The tumor was occupied by a tough, putty-like substance, and had evidently originated in a sebaceous follicle.

An instance of a similar kind, successfully treated by operation, came under my observation at the College Clinic, in 1871, in a young woman, twenty-four years old. The tumor, the size of a common orange, had commenced at the age of twelve, and occupied the thyro-hyoid region, to the membrane of which it had contracted very firm adhesions.

Deep epidermic cysts, or pearly tumors, probably originating in the chain of lymphatic glands along the sheath of the carotid vessels, with which they are intimately connected, have been observed by Adelman, Thiele, Langenbeck, and other surgeons. The best description of these growths, and of the operations required for their removal, with which I am acquainted, has been furnished by Langenbeck, in a valuable article, entitled "*Beiträge zur Chirurgischen Pathologie der Venen*" in the first volume of his *Archiv*. Invariably situated in the carotid triangle above the omo-hyoid muscle, usually on the left side, they give rise to smooth, elastic tumors, of a rounded, ovoidal, or fusiform outline, corresponding to the direction of the great

vessels, from which they receive distinct pulsation. Pulpy fluctuation may be detected by palpation with one finger in the pharynx and another on the surface; while the imparted pulsation ceases by drawing the head downwards and to the corresponding side. The only efficient remedy is extirpation by a careful dissection, lest the carotid vessels be wounded. In one of his cases Langenbeck excised a small portion of the internal jugular vein, the walls of which were closely attached to, if not actually incorporated with, the posterior surface of the cyst.

4. *Fibrous Tumors*.—A fibrous tumor now and then forms in front and at the side of the neck, and may, in time, acquire an enormous bulk, seriously interfering with the patient's looks and comfort. The annexed drawing, fig. 319, exhibits a growth of this description, removed by me from a youth of seventeen. It had been in progress for several years, and, although free from pain, was productive of great inconvenience. After removal, it was found to

Fig. 319.



Fibrous Tumor of the Neck.

weigh upwards of five pounds, and to present a beautiful specimen of the fibrous structure. The tumor was situated superficially, but much care was, nevertheless, required in its excision on account of the great enlargement of the subcutaneous and other veins. No untoward symptoms followed the operation.

5. *Fatty Tumors*.—Fatty tumors of the neck are very uncommon. They are distinguished by their tardy growth, their mobility, their doughy, inelastic consistence,

and their freedom from pain, joined to the integrity of the general health, and the absence of discoloration of the skin. Adults and elderly subjects are most liable to them. They seldom attain much bulk. Care should be taken not to confound them with chronic abscesses. When the diagnosis is doubtful, the exploring needle must be employed. The proper course is extirpation, and this may generally be effected by enucleation.

6. *Serous and Bloody Tumors*.—A cystic tumor, occupied by serum, blood, or sanguinolent matter, occasionally forms in front of the neck, between the sternum and the thyroid gland, taking its rise apparently in the cellular substance between the sterno-hyoid and sterno-thyroid muscles. Its progress is chronic, and it seldom acquires a volume larger than that of a small orange, which it also generally resembles in shape. It fluctuates distinctly under pressure, is free from pain, and readily obeys the movements of the larynx during efforts at deglutition, rising as the tube ascends, and falling as it descends; circumstances which, together with its tardy development, the absence of enlargement of the subcutaneous veins, and the impaired condition of the general health, are always diagnostic of the nature of the affection. The cystic tumor, according to my observation, is almost exclusively met with in young and middle-aged females. Cases occur in which it is congenital.

The proper remedy for this morbid growth is excision, which, with ordinary care, may always be performed with perfect safety. The knife should be used in such a manner as not to penetrate the cyst, since, if this happen, the operation will be one of great difficulty, whereas, under opposite circumstances, removal may generally be effected by enucleation. Very little hemorrhage attends the procedure, and the recovery is usually rapid. I have seen a number of cases where this tumor was greatly diminished by the long-continued application of iodine, but I have never known the treatment to be followed by a permanent cure. Mr. Stanley has recorded the particulars of a cystic tumor at the side of the neck, in a lad sixteen years of age, which, on being punctured, gave vent to a pint of fluid blood, and never refilled, this simple treatment sufficing to effect obliteration of its cavity.

A very extraordinary case of cystic tumor of the neck and chest, of enormous size, was published in the North American Medico-Chirurgical Review, for March, 1860, by Dr. O. B. Knobe, of Missouri. Occupying the anterior cervical region, it extended outwards on each side nearly to the shoulder, and down some distance below the ensiform cartilage, being eighteen inches in length, and more than two feet in circumference. It fluctuated distinctly on pressure, and contained a gallon and three pints of inodorous and insipid fluid, of the color and consistence of weak coffee. When the fluid had been withdrawn, a hard, nodulated mass, as large as a double fist, was found with strong attachments to the hyoid bone, thyroid cartilage, and sterno-cleido-mastoid muscle. Immediately after the operation, the parts were firmly strapped with adhesive plaster, and the patient put under the use of iodide of potassium, in doses of five grains thrice a day. At the end of a fortnight, the fluid had reaccumulated to the extent of two quarts. It was again evacuated and the part strapped as before. In less than a week, all discharge had ceased, and the solid mass gradually diminished in size, and the man eventually completely recovered.

7. *Congenital Cystic Tumors*.—Under this denomination may be described a form of tumor which, commencing as an intra-uterine affection, not unfrequently extends far into adult life, often acquiring an enormous bulk, and giving rise to great deformity. In a case recently under my observation, the tumor, situated on the left side of the neck, was, at birth, of the volume nearly of a double fist. Dr. Adolph Wernher has described the disease very accurately under the name of cystic hygroma, while others have characterized it as hydrocele of the neck.

The growth occurs in two varieties of form, the unilocular and the multilocular, of which the latter is by far the more common. The cyst is composed of fibrous tissue, of a pale, whitish appearance, and of a tough consistence. The cavities, in the multilocular tumor, range in size from a pea up to that of an orange; their form is generally irregularly rounded, and their walls are, for the most part, very thin in early life, but often very thick, dense, and firm, in cases of long standing. The outer surface of the cyst is more or less rough; the inner, smooth and glistening. In very young infants, the cyst, when completely uncovered, or divested of extraneous matter, is frequently as thin and transparent as a child's bladder.

The origin of compound congenital cysts of the neck is supposed, by some, to be intimately connected with the intercarotid ganglion, first described by Luschka,

and represented by him as consisting of a follicular structure, similar to that of the coccygeal gland. Doubt, however, has been thrown upon this conclusion by the researches of Julius Arnold, who inclines to the opinion that the intercarotid ganglion is essentially a plexus of nerves enveloped in soft matter, divisible into small, separate masses.

The contents of the tumor are either clear and limpid, or of a pale brownish or reddish hue, from being stained with blood; saline in taste; and coagulate by heat, alcohol, and acids. Sometimes they are of a grayish color, and of the consistence of gruel. In rare cases, there is an admixture of fluid and solid matter, in varying proportions. Otto has reported an instance in which firm, fleshy masses were found within the growth, and I have met with a similar occurrence.

The most common situation of the congenital cystic tumor is the side of the neck, but it may occur in any portion of the cervical region, in front, laterally, or posteriorly, lying underneath the deep fascia, and sending processes about in different directions among the muscles, glands, vessels, and nerves, which are literally buried in its substance. The growth is generally attached more or less extensively to the vertebræ, and, for this reason, cannot always be completely excised.

The surface of the multilocular tumor is generally more or less tuberculated, dimpled, or nodulated, free from discoloration, and easily indented with the finger. The fluctuation is always distinct, although seldom uniform, for, while some portions of the growth are perfectly fluid, others, as previously stated, are semisolid, and, in great degree, devoid of elasticity. Occasionally the surface has a bluish tinge; and, now and then, an instance is seen in which there is a remarkable enlargement of the subcutaneous veins, amounting almost to complete varicosity. The surface of the unilocular cyst is generally smooth.

The diagnosis of the disease is deduced from the history of the case, the fluctuation, the absence of pain, and, when great doubt exists, by the cautious use of the exploring needle. The general health is never impaired, except when the tumor injuriously compresses the trachea and the great vessels and nerves of the neck; a circumstance of rare occurrence.

The congenital cystic tumor of the neck sometimes disappears spontaneously, or under the influence of discutient remedies, of which mild solutions of hydrochlorate of ammonia and the dilute ointment of biniodide of mercury are the most reliable. Temporary relief may be afforded with the trocar. A radical cure can only be effected by iodine injections, the free division of the tumor, and the use of a tent, the introduction of the seton, and excision, the latter of which, if I may judge from personal experience, is always the safest, provided the growth is not very bulky and does not send numerous processes among the muscles, nerves, and vessels of the neck. In such an event, excision is not only exceedingly difficult and tedious, but full of risk. Now and then, however, an exception occurs, as in the case of a child, six weeks old, from whom I removed, in 1862, without an untoward symptom, an immense tumor of this kind, extending, on the one hand, from above the ear to the clavicle, and, on the other, from the trachea near to the middle line of the neck behind. The cyst was multilocular, with extensive processes dipping in among the muscles.

The seton is hardly a safe remedy in the treatment of the congenital cystic tumor of the neck; more especially if it be of large size, or dips down extensively among the muscles, as it is liable to be followed by great difficulty of respiration and deglutition, in connection with severe constitutional disturbance. Injection with iodine is occasionally followed by similar effects.

8. *Malignant Tumors.*—Malignant tumors of the neck, of the nature of medullary lymphoma, sarcoma, encephaloid, and epithelioma, occasionally occur, generally commencing in the lymphatic glands, and capable of attaining an enormous bulk, as seen in fig. 320. They are nodulated in appearance, rather diffused than circumscribed in shape, soft, and apparently fluctuating at some points, and hard at others; the integument soon becomes adherent and discolored, to be followed by ulceration, with profuse discharge, and repeated, exhausting hemorrhage. Their growth is usually rapid, and this fact, together with the history of the case, and the development of the peculiar cachexia of carcinoma, is always sufficient to distinguish them from benign growths. The discrimination, however, between these different forms of malignant disease is extremely difficult without the aid of the microscope, and this is particularly true of medullary lymphoma, lymphosarcoma, and encephaloid. Epithelioma is of dense consistence, tardy progress, and does not attain any very

considerable bulk, while encephaloid is marked by great enlargement of the superficial veins, which is rarely, if ever, the case in lymphoma and sarcoma, both of which, moreover, acquire greater dimensions, have a more rapid growth, and are more closely adherent to the skin and surrounding parts than the former. From my own observations, I am led to believe that the mode of development forms the best test between the sarcomatous and carcinomatous affections. In sarcoma, the tumor, having attained a certain volume, remains stationary, perhaps, for several months, when, under the influence of some exciting cause, it suddenly resumes its growth, and proceeds uninterruptedly to its termination. In carcinoma, on the other hand, the growth is progressive, or not marked by intermission.

Fig. 320.



Encephaloid Tumor of the Neck.

Operative interference should be avoided when the tumor has contracted extensive and firm attachments, which is always the case when it is of large size, the great vessels and nerves often being found to be included in its midst. Many of these growths, indeed, originate in the lymphatic glands along the carotid sheath, rendering the great vessels very liable to be wounded in their removal. Extirpation, however, may be attempted when the tumor is small and movable, but, even under these otherwise favorable conditions, it is very liable to return.

The recurring tendency of sarcoma, after operation, is well illustrated in a case that came under my care in 1871, in a man, aged twenty-seven. One year and a half previously, he noticed a lump, of the size of a cherry, beneath the angle of the jaw, after an attack of quinsy, which remained stationary for sixteen months, when it began to enlarge until it attained the volume of a walnut with its hull. At this time, or on the 26th of June, it was removed by his family physician, but it immediately returned in the cicatrice and the subcutaneous connective tissue. On the 28th of August, I excised the new growth, which filled the space beneath the jaw, and was as large as a hen's egg, along with the submaxillary gland, with which it was intimately connected. Another tumor of the same size soon developed, which I removed on the 8th of November. It was seated over the parotid region, and differed from the former growth in the greater adhesion and discoloration of the skin, and its softer consistence. Both neoplasms proved to be small, round-celled sarcomas, the cells being closely packed, and containing large nuclei with bright nucleoli. Up to the present time, four months after the third operation, the patient continues well.

9. *Hypertrophy of the Sterno-mastoid Muscle.*—In connection with the morbid growths of the neck, may be noticed a singular congenital disease, if so it may be termed, of the sterno-mastoid muscle, in which that muscle is converted into a hard, firm mass, of irregular outline, bearing a considerable resemblance to a tumor. The affection, which has been particularly described by Bryant and Holmes, in their treatises on the "Surgical Diseases of Children," is very uncommon, and presents itself as an innocent swelling, the result, apparently, of inflammatory deposits, involving the muscle, either in its whole length, or in the greater portion of its extent. The precise nature of the complaint is not well understood, as no opportunity has occurred, in any of the reported cases, of making a dissection of the parts. The probability, however, is that it is simply a congenital hypertrophy of the constituent elements of the mastoid muscle, developed under the influence of irritating causes. The diagnosis is generally easy, and the affection commonly soon disappears under gentle sorbefacient applications.

10. *Operations upon the Neck.*—The operations necessary for the removal of tumors of the neck are often of the most difficult, perplexing, and bloody character. This is true alike of those of a benign and of a malignant structure, especially when

they are large or deep-seated, involving important vessels and nerves, and forming strong attachments, not only to the muscles and aponeuroses, but also to the bones, especially the cervical vertebræ. In the superior part of the neck, they frequently extend high up into the parotid region, where they dip in between the ear and the lower jaw, sending processes about in every direction, some of which occasionally reach as far as the mucous membrane of the pharynx. On the other hand, a tumor of the face not unfrequently passes down into the neck, forming thus firm and intimate connections with the parts in this situation. In the inferior cervical region, a growth of this kind often extends beneath the clavicle, and sometimes even beneath the scapula. Fibrous and glandular formations are very prone to take this course, and the consequence is that they are generally extirpated with great difficulty, a long and elaborate dissection being necessary to effect their liberation. Occasionally the morbid mass is so completely buried among the muscles, vessels, and nerves, as to render their isolation absolutely impossible. When the pressure of the tumor is very great, and long continued, it may induce obliteration of the jugular vein, and even of the primitive carotid artery.

Unless the surgeon is well acquainted with the nature and habits of these growths, and also with the anatomy of the cervical region, he will find himself bewildered at every step of his progress, and be, probably, at length compelled to leave his task partially unfinished. When the growth is seated along the base of the jaw, the incision should, as a general rule, be curvilinear, in close proximity to the bone, as this will be the least likely to be followed by a disfiguring scar. Sometimes a crucial, T or V-shaped incision is necessary. A similar proceeding is usually required in operating upon the inferior part of the cervical region. In front of the neck, the incision should usually be oblique, in the line of the sterno-cleido-mastoid muscle, and this course should generally be pursued whether the growth lie on the inside or on the outside of this muscle. In many cases, the tumor will be found to be so thoroughly tied down by it as to require its division early in the operation. The deeper attachments should always, if possible, be severed with the finger, or with the handle of the scalpel, the separation being conducted from below upwards. If the point of the instrument is used for this purpose, great, if not irreparable, mischief may be caused. Sometimes the surgeon is reluctantly compelled to leave a portion of the morbid growth, owing to the extraordinary depth to which it passes, or to the nature of its attachments. In such an event, a ligature should be cast firmly around it before the main mass is liberated.

It is very important during the after-treatment in all severe operations upon the neck, especially in those involving exposure of the windpipe, to keep the patient in a properly regulated atmosphere, in the same manner and for the same reason as in tracheotomy and laryngotomy. The contact of cold air is highly injurious, predisposing to the occurrence of pneumonia, one of the most fatal effects of such undertakings.

All arteries should, as a general rule, be tied as soon as they are divided; or, if very large and deep-seated, before they are divided, and the large veins should be dealt with in a similar manner. Any veins that may be imbedded in the morbid growth and that cannot be separated by the cautious use of the knife and other means, should be included in two ligatures, and divided in the interval. Unless these precautions be observed, there will be great risk of the entrance of air, not to say anything of hemorrhage, which would often be very copious, if not positively fatal. So far as my observation goes, it is never necessary, in any of the operations upon this region, to ligate, as a preliminary step, the common carotid artery. This artery, however, may occasionally require a ligature after the excision of the morbid growth is completed, especially when the bleeding vessels are very deep-seated, and the hemorrhage cannot be controlled in the ordinary manner. I have on two occasions been obliged, under such circumstances, to resort to this expedient, in each instance with the happiest results.

Great care must be taken not to wound any important nerves, as the phrenic or pneumogastric. Experience has shown that no harm results from the division of the spinal accessory and cervical nerves, properly so called, or of the descending branch of the ninth pair.

In order to effect thorough approximation of the sides of the wound, a matter of great importance after operations on the neck, the most efficient means is a soft, wet sponge, placed in immediate contact with the flaps, and confined by a muslin compress

and a roller. The sponge thus used serves the double purpose of a compressing and of an absorbent agent, at the same time that it excludes the air and supports the bloodvessels.

In summing up the general characters of operations upon the neck, for the removal of morbid growths, the great points to be considered are, first, the difficulty of their execution, and, secondly, their liability to be attended with profuse hemorrhage, injury to important nerves, and the entrance of air into the veins. The after-treatment should always be conducted with special reference to the avoidance of erysipelas, pyemia, and diffuse inflammation. Despite, however, the closest and most skilful attention, the patient will not unfrequently perish.

Cystic tumors of the neck are particularly difficult of extirpation. The embarrassment is always greatly augmented when the cyst is inadvertently punctured, so as to permit of the escape of its contents and the collapse of its walls. Such an occurrence may generally be effectually prevented by the free but very cautious use of the grooved director, layer after layer of the superimposed structures being divided, until the morbid growth is so completely denuded as to admit of its easy enucleation with the finger or the handle of the scalpel. In old cysts of large size, the number of these adventitious investments is generally surprisingly great, and hence, if the operator is not very guarded, he will be almost sure to penetrate the proper tunic before he is aware of it.

No statistical inquiry has, I believe, been made to show the mortality of extirpation of tumors of this region. In a paper referring to wounds of the internal jugular vein, published in the *American Journal of the Medical Sciences* for January and April, 1867, Dr. S. W. Gross has found that this vein was injured thirty-seven times in the removal of tumors. The greater number of these growths were of a malignant nature, and their connections were deep and extensive, so that in seven not only the jugular vein, but the carotid artery also required deligation. In one case the pneumogastric nerve was divided, the patient, notwithstanding this untoward circumstance, making a good recovery, being the third instance of the kind on record. Of the 37 cases, 13, or 35 per cent., terminated fatally; the causes of death being the entrance of air in 4, exhaustion in 4, secondary hemorrhage from the vein in 3, and pyemia and bronchitis, each in 1. The infrequency of pyemia after operations of such magnitude is remarkable.

SECT. VI.—ABSCESSSES AND FISTULES OF THE NECK.

There is no region of the body in which abscesses are so frequent as in the neck, or so difficult of diagnosis and treatment. Liable to occur at all periods of life, and under all conceivable circumstances, they may be common or specific, acute or chronic, superficial or deep, large or small, bold or stealthy in their origin and progress. Their favorite seat is the upper and lateral part of the neck.

Among the more common causes of cervical abscesses are, exposure to cold or the sudden suppression of the cutaneous perspiration, disease of the teeth, gums, and lower jaw, and the exhausting and poisonous effects of measles, scarlatina, and typhoid fever. Scrofulous persons are particularly liable to their formation from the most trivial circumstances. A bad form of abscess of the neck occasionally arises from disease of the tongue, hyoid bone, larynx, trachea, fauces, or œsophagus.

However induced, cervical abscesses are commonly ushered in by more or less general disorder, attended with severe pain, swelling, and induration. When situated superficially, the skin becomes early discolored, assuming a purplish and congested appearance, and distinct fluctuation is soon perceptible. When, on the contrary, the matter is deep seated, the skin may for a long time retain its normal aspect, and fluctuation may either be entirely absent, or else show itself only as the fluid approaches the surface. Severe, tensive, throbbing pain usually attends the more aggravated forms of the complaint, the movements of the neck are greatly impeded, the patient swallows with difficulty, and even the respiration may be seriously embarrassed, simply from the extension of the inflammation or from the pressure of the accumulating fluid.

Owing to the remarkable laxity of the cellular substance of the neck, and the great firmness of its aponeuroses, the tendency of these abscesses is to burrow extensively among the muscles, the pus often passing down below the clavicle and around the great vessels, windpipe, pharynx, and œsophagus. Such an event is particularly

liable to occur in weekly, scrofulous children, the subjects of scarlatina, measles, smallpox, and typhoid fever, and also in old, broken-down, anemic persons, in whom the morbid action frequently spreads with extraordinary rapidity, the tissues readily yielding to its devastating influence. In general, the matter is finally evacuated through the skin, but cases are occasionally met with in which it bursts into the anterior mediastinum, the fauces, œsophagus, windpipe, the carotid artery, or even the internal jugular vein.

In a paper published in the American Journal of the Medical Sciences for April, 1871, Dr. S. W. Gross has collected and analyzed thirty-eight cases, including one under his own care, of communication between the cervical vessels and abscesses or open sores, from which it would appear that the large venous and arterial trunks are more liable to be opened than their branches. The internal jugular vein was involved in twelve, and the external jugular in one; in at least ten instances the accident occurred in children after an attack of scarlatina, while in two it was due to the extension of inflammation to the coats of the vessel from a scrofulous abscess and ulcer. All of the cases perished from hemorrhage, generally of a recurrent character, immediate death having taken place only in three. Of the arteries, the common carotid was the seat of the lesion five times; the internal carotid three times; the subclavian once; the superior thyroid twice; and the lingual, facial, and inferior thyroid, each once. In eleven instances the precise vessel was unknown. Of these twenty-five cases, the majority of which occurred in children debilitated by eruptive fevers, six were saved by ligation of the common carotid, one by tying the external carotid, and three by direct compression. All of the remainder were fatal, inclusive of two deligations of the common carotid, and one of the internal carotid.

The treatment of these abscesses must be conducted upon general principles, due regard being had to their nature and to the condition of the system, which is often greatly disordered, and, therefore, requires to be amended. A course of tonics and alterants will frequently prove highly efficacious. The best local remedies are leeches, blisters, iodine, cataplasms, and saturnine lotions. Matter should be evacuated early, by suitable incisions, made in such a manner as not to interfere with any important vessels, or to leave any disfiguring scars. When the healing process is sluggish, a healthful stimulus may be imparted to the sore by the application of nitrate of silver, or injections of iodine, sulphate of copper, or acid nitrate of mercury.

The *synovial bursæ* in front of the neck, and the structures immediately over it, are liable to suffer from abscess, either as an independent affection or as a result of reflected irritation from the throat, windpipe, or lungs. The disease is sometimes so obscure as to elude detection during life. In general, however, there are more or less tumefaction, difficulty of swallowing, spasmodic coughing, and a sense of strangulation. An early incision is required, to prevent the abscess from bursting into the windpipe.

A *congenital fistule* is occasionally met with in this situation. It is commonly single, incomplete, and so small as hardly to admit of the introduction of the finest probe. Of 65 cases, collected and analyzed by Dr. George Fischer, including 79 fistules, both sides of the neck being affected in 14, 20 were complete and 53 incomplete, the latter having no internal opening. In 47 instances the outer orifice was seated on the right side, and in 27 on the left, almost uniformly a few lines above the sterno-clavicular articulation. The internal aperture is generally found on the wall of the pharynx, in the vicinity of the great horn of the hyoid bone, the track itself being narrow, lined with mucous membrane, and lying parallel with the trachea. In a case of double fistule, described by Mayr, one of the canals communicated with the trachea, and the other with the œsophagus. Such an affection seldom requires surgical interference, as it is not often productive of any special inconvenience. A cure may, if necessary, be attempted by the use of a heated probe, or of a probe moistened with a solution of nitric acid. If this fail, the parts should be freely divided, and healed from the bottom with the aid of a delicate tent.

A very rare form of fistule, to which the term *lymph fistule* may be applied, is sometimes met with in the neck, generally at or near the middle line, discharging a thin, limpid fluid, possessing all the properties of ordinary lymph. The orifice leading to the fistule seldom exceeds the size of a common bristle. The affection is usually congenital, and is evidently dependent upon the imperfect closure of one of the lymphatic vessels of the neck. The treatment is similar to that of congenital fistule described in the preceding paragraph.

SECT. VII.—AFFECTIONS OF THE HYOID BONE.

The hyoid bone, from its peculiar situation and relations, is liable to various diseases, some of which originate in its own structure, while others are communicated to it from the surrounding parts. These affections have been described with great care by Dr. Gibb, in his monograph on the Diseases of the Throat and Windpipe, and are deserving of special attention. Fractures and dislocations of the hyoid bone are treated of in the first volume.

Inflammation of the hyoid bone may arise from external injury, or from the effects of syphilitic and other diseases. It generally begins in the fibrous covering of the bone, and occasions more or less swelling of the neck, severe pain, dysphagia, and difficulty of respiration. By and by, matter forms, and, if not speedily evacuated, may cause extensive havoc among the surrounding structures, attended by an increase of all the local phenomena here alluded to. The treatment must be strictly antiphlogistic, with leeches, iodine and blisters to the neck, and an early and free incision, to afford vent to pent-up fluids.

When necrosis occurs it may be limited to a particular portion of this bone, as to one of its horns, or it may affect one-half or even its entire substance, as in a case recorded by Rozart. The patient, a lady, aged thirty-six, was of a scrofulous habit, and had been ill for five years, when she coughed up the dead bone, and immediately recovered. A similar case has been described by Sprey. The disease is frequently associated with ulceration of the larynx and throat. As soon as the bone is sufficiently isolated, it should be removed with the knife and forceps.

The hyoid bone is sometimes eburnized, or converted into a hard, ivory-like substance; and Warren alludes to an instance in which the right horn was the seat of a conical exostosis, nearly three inches in length. In elderly subjects the thyro-hyoid articulations are sometimes completely ankylosed.

Wounds of this bone are uncommon. They are generally the result of gunshot injury, or of violence inflicted in attempts at suicide, and are to be treated upon the same principles as similar lesions of the larynx and trachea. A severe contusion is sometimes followed by serious consequences, as abscess, caries, and necrosis.

CHAPTER XI.

INJURIES AND DISEASES OF THE CHEST.

SECT. I.—WOUNDS OF THE CHEST AND LUNGS.

WOUNDS of the chest, like those of the abdomen, necessarily divide themselves into external and internal, or those which affect the wall of the chest, and those which implicate its contents. They may, as in other parts of the body, be of various kinds, as incised, lacerated, punctured, or gunshot, and they may be either simple or complicated, according to the nature and amount of tissue involved in the injury.

External wounds of the chest, unless accompanied by severe concussion, profuse hemorrhage, or fracture of the ribs, are rarely attended with any particular danger, and require no other treatment than that which regulates the conduct of the practitioner in the management of wounds in general. When the lesion is considerable, it may be necessary, especially if the patient is harassed with cough, to adopt means for securing the quietude of the chest by the application of a broad bandage and the occasional exhibition of an anodyne draught; but under ordinary circumstances both these expedients may be dispensed with. Any foreign substance, as a splinter of wood, a ball, or a loose piece of bone, must, of course, be removed, either on the instant, or as soon as its situation is rendered obvious. The direction which a ball sometimes pursues upon striking the chest, especially if it comes in contact with the sternum, spine, or ribs, is very remarkable. Thus, instead of lodging at or near the point of entrance, it has been known to make almost the entire circuit of the thorax, passing underneath the integument, and becoming arrested a short distance from

the point of ingress, or, perhaps, issuing even at the same orifice, as has occasionally happened in military engagements. When this is the case, the course of the projectile is generally indicated by a reddish or purplish line, which will be more distinct in proportion to the size of the ball; and, in addition to this, there is not unfrequently a crackling sensation imparted to the finger as it sweeps over the chest in pursuit of the intruder, caused by the presence of air. In some instances the ball lodges between two ribs, perhaps splintering them, and finally effecting an entrance into their substance.

When two openings exist in the chest, the probability is that the ball has escaped, and yet it is possible that a portion of it may have been cut off, and retained. The orifice of entrance is usually readily distinguishable by the fact that, if a bone has been struck, the fragments will be forced inwards towards the lungs, whereas they will be pushed outwards at the orifice of egress. When the missile comes in contact with a costal cartilage, it simply breaks it, without carrying any of its substance into the chest. Sometimes a bullet perforates the lung, and lodges under the skin, opposite its point of entrance. When this is the case, the air may escape from the thoracic cavity into the subcutaneous cellular tissue, and be thus more or less extensively diffused over the body.

External wounds of the chest are seldom attended with much hemorrhage; it is only when an intercostal artery is laid open that there will be likely to be much bleeding, and in that event the vessel must, of course, be secured with the ligature. The operation, however, is generally difficult, if not impossible, owing to the deep situation of the vessel. When this is the case, I should not hesitate to drill a small aperture into the rib, immediately above the artery, and to pass a silver wire around its bleeding orifice. Such a procedure, although apparently harsh, would not involve any special risk from inflammation of the pleura. Lesion of the internal mammary artery is occasionally followed by hemorrhage into the anterior mediastinum. When the quantity of blood effused is so copious as to compress the heart and lungs, or to cause great exhaustion, the only thing to be done is to expose and ligate the vessel at all hazard.

Wounds involving fracture of the ribs or sternum must be treated upon the same general principles as fracture of these bones without such lesion of the soft parts; that is, the movements of the thorax must be controlled with the bandage, and cough and pain allayed by anodynes and appropriate antiphlogistic measures.

The lungs are sometimes seriously, if, indeed, not fatally, injured without any apparent lesion of the walls of the chest. A young man, while riding, fell from his horse on his left arm. He complained of no pain, but twelve hours after he was seized with alarming hemoptysis, and died in a few days. The dissection revealed an extensive laceration of the posterior part of the right lung, and a copious effusion of blood into the pleural sac, without any external sign of violence. A similar accident has occasionally been produced by a fall from a scaffolding, and by the passage of the wheel of a cart, as in a case reported by Dr. Edward Hartshorne. The occurrence of such a lesion, sixteen cases of which have been collected by Dr. John Ashurst, is easily explained by supposing that the lungs, at the moment of the accident, are forcibly distended with air, so that the walls of the chest, on being brought violently in contact with them, readily cause their rupture.

A ball striking the chest, without leaving any other mark upon the skin than, perhaps, a slight weal, not unfrequently produces violent effects; primarily severe, if not fatal, shock, with more or less hemoptysis, and, secondarily, intense inflammation of the lung, or lung and pleura, followed, occasionally, by profuse empyema and an attempt on the part of the pent-up fluid to escape externally, its progress being sometimes denoted by the existence of air under the integument.

Internal wounds of the chest are much more serious accidents than external; they are generally made by balls and sharp-pointed instruments, as knives, dirks, lances, sabres, or bayonets, and are often attended with severe lesion of the contents of the thoracic cavity, terminating life either on the spot, or at a period more or less remote from the occurrence of the injury. Hence their effects may conveniently be arranged under two heads, the primary and secondary; the former including shock, collapse of the lung, hemorrhage, and pneumothorax; the latter, inflammation and its consequences, as accumulations of serum, lymph, and pus in the pleural cavity.

Internal wounds of the thorax may be further divided into those which merely

pierce its walls, without inflicting any injury upon its contents, and those in which the contents participate in the mischief.

Death from mere shock is by no means uncommon in wounds and injuries of the chest; cases of the kind are frequently met with both in civil and military practice, and their occurrence has occasionally been noticed where, upon dissection, no serious lesion has been detected to account for so untoward a result. The treatment of such cases does not involve anything peculiar, as it does not differ from that of shock from other causes. Our principal reliance must necessarily be upon sinapisms and stimulants, especially in the form of enemata, with opium, to calm the nervous system and sustain the heart's action; but great caution should be observed in their use, particularly if there is reason to believe that the depression is dependent, in part, upon intrathoracic hemorrhage, lest, by the induction of early reaction, the bleeding should be encouraged instead of being repressed.

Collapse of the lung is much less frequent than was formerly supposed, and is not, by any means, a necessary effect of a penetrating wound of the chest. The occurrence will be most likely to happen when the wound is direct and of large size; under opposite circumstances, and especially when the opening presents a valvular arrangement, or when the passage leading from it is long and devious, the air will find it difficult, if not impossible, to enter the chest to such an extent as to counterbalance that in the lung, which will thus, consequently, retain its natural position. Even when the wound is of considerable size, the organ is sometimes found to resist collapse, as is proved by the fact both that the respiration is unembarrassed and that the lung is seen moving to and fro beneath the aperture in the thoracic wall. Still more satisfactory proof is occasionally furnished by the protrusion of a portion of the lung across the wound in the chest, thus constituting what has curiously enough been called pulmonary hernia, or pneumonocoele.

Collapse of the lung is always a serious occurrence, as the patient is thus generally instantly deprived of one-half the quantity of air which he was accustomed to breathe before the injury; if both sides are similarly affected, the difficulty will, of course, be proportionately increased, although even then the case is not necessarily fatal, for both clinical observation and experiments on the inferior animals have shown that the lungs, under these circumstances, so far from collapsing, may become so completely distended with air as to project from the thoracic cavity at each opening, and yet the subject make a very rapid and satisfactory recovery. It is not improbable that the state of the patient's strength exerts considerable influence upon the production of collapse, the accident being more likely to take place when he is exhausted by shock and loss of blood than when he is able to command the free use of his respiratory muscles. In the former case, he is very much in the condition of a person who is partially asphyxiated, and, consequently, incapable of distending his lungs, which are thus easily collapsed by the accidental ingress of the smallest quantity of air; in the latter, on the contrary, his efforts, which are often very violent, enable him effectually to resist the encroachment, and even to force the lungs somewhat out of the chest.

Collapse of the lung is characterized by excessive dyspnoea, the patient struggling violently for breath, and throwing himself about in the greatest distress and anguish; the ribs on the affected side are immovable, the respiratory murmur is completely absent, the voice is weak and indistinct, and percussion elicits an unusually clear resonance. With these symptoms are conjoined those of sudden and severe prostration, as excessive pallor of the countenance, a feeble, almost imperceptible pulse, and clammy sweats, followed by coldness of the extremities.

When the chest is pierced without collapse of the lung, the air generally makes a peculiar noise as it rushes into the pleural sac; and, if the opening of communication is sufficiently large, the lung may be seen to move up and down in consonance with the egress and ingress of the air, filling, perhaps, the whole, or, at any rate, the greater portion, of the thoracic cavity. The voice is not materially changed, if at all, and the vesicular murmur is nearly natural, although the respiration is performed with great labor and difficulty. Soon after the accident, there will be an escape of blood at the wound at each effort at inspiration, and, if the pulmonary tissue has been injured, the patient will cough up blood, or, perhaps, have actual hemoptysis, especially if some of the larger vessels have been divided. A discharge of blood by the mouth, however, is not a positive evidence of penetration of the lung,

experience having shown that the mere concussion of the chest by a ball or shot is capable of producing it.

The *prognosis* of penetrating wounds of the chest is exceedingly unfavorable. In many of the cases, life, as above stated, is destroyed on the instant, or, at all events, shortly after the infliction of the injury, either by shock or hemorrhage, or the two together. When both sides are pierced, death may take place from collapse of the lungs, although such an event is much less frequent than is commonly supposed. Should the patient be so fortunate as to escape from the immediate effects of the lesion, he will stand a fair chance of perishing from inflammation of the lungs and pleura; or, surmounting this, from pyemia or hectic irritation.

Gunshot wounds of the chest are generally much more dangerous than wounds inflicted with the lance, sabre, or bayonet, owing to the fact that they are attended with more laceration, and frequently also with the lodgment of the bullet and other foreign matter. A penetrating wound of the apex of the lung is not so dangerous as one of the root of this organ, as it is less liable to be followed by copious hemorrhage and severe inflammation. In the old mode of warfare, more than half of those who were shot through the chest died, but this ratio has been immensely increased since the introduction of the conical ball. The mortality from this cause in the Russian army at the siege of Sebastopol was most appalling, only 3 out of 200 having recovered. In the British army, on the contrary, during the same campaign, 27 out of 147 were saved. The fatality in this class of injuries is, doubtless, much influenced by the mode of treatment and other attentions received by the wounded. The Russian surgeons relied chiefly upon the use of digitalis; the British, upon copious venesection. During our late war, in which bloodletting was almost entirely abandoned, of 1272 penetrating wounds of the chest, 930, or 73 per cent., perished.

The ball, in wounds of this kind, instead of penetrating the lung, is occasionally arrested in the pleural cavity, in contact with the upper surface of the diaphragm, as in the case of a young man, a patient of mine, who was injured by a pistol shot. The outer opening gradually closed, but violent inflammation soon set in, followed by copious sero-purulent effusion, terminating in death at the end of four weeks. No perceptible lesion could be discovered in the lung, showing that the ball, after passing through the thoracic wall, must either have rebounded upon touching that organ, or else dropped down into the chest by the force of its own weight.

The *treatment* of penetrating wounds of the chest requires, in the first place, accurate closure of the orifice of communication, provided there are no contra-indications; and, in the second, the employment of such measures as may tend to prevent the occurrence of severe inflammation of the pleura and lung, which is so liable to happen after all injuries of this kind, even when the latter organ is not directly implicated. The treatment of hemorrhage will be considered under the head of hemothorax.

Any foreign substance that may be present should promptly be removed, provided it is easily accessible; for the rule here, as in all other visceral cavities, is to refrain from officious interference. Nothing, in such a condition, can more clearly betray the ignorance of the surgeon than the introduction of the probe into the chest; a careful exploration of the outer wound is always admissible, especially when suspicion exists that a rib has been fractured, or that a ball has lodged in one of the intercostal spaces. If a probe be required, the finger, if not too large, will always answer that object better than anything else.

When a ball lies loose in the cavity of the chest, as in the case above mentioned, the result must almost necessarily be fatal. There is the merest possibility that it might become encysted, or buried in a mass of organizable lymph, and thus remain, at least for a time, a harmless tenant.

I have met with cases of shot wounds of the chest where the ribs were so much splintered as to require removal with the cutting-pliers; but the instances demanding such a procedure must necessarily be uncommon, and, in general, the duty of the surgeon is limited to the extraction of the loose, or partially detached, fragments. Such cases, it need hardly be added, are extremely liable to prove fatal.

If the lung is collapsed, an attempt may be made to draw the air out of the thoracic cavity with a large syringe, although such a procedure will generally be unnecessary, as the organ will of its own accord soon regain its natural position. If a portion of lung protrude, or puff out through the wound, it should immediately be returned, and proper means taken to prevent a recurrence of the accident. On no

account should it be excised, not even if it is gangrenous, as it might be if a number of days have elapsed since the receipt of the injury, or if the patient have been injudiciously treated. In such a condition, the separation of the slough should be promoted by mild applications; when this has been effected, any outward tendency in the lung may easily be counteracted by graduated compression during the granulating and cicatrizing processes.

When the wound is very large, it should be closed with a suitable compress and adhesive strips, or collodion plaster. Cases occur in which, when the orifice is very capacious, occlusion may be effected by sliding the integument down over it from the parts in its immediate vicinity. Such a procedure would, of course, be objectionable when there is extensive injury of the bony case of the chest.

Dr. Benjamin Howard, formerly of the army, recommends a plan of treatment in gunshot wounds of the chest, which he calls "hermetical sealing." It simply consists in cutting away the contused structures down to the ribs, so as to convert the wound into an incised one of an elliptical form, and in effecting close and accurate approximation with silver sutures, deeply inserted, at a distance of a quarter of an inch from each other. The dressing is completed by carefully wiping the surface, and then covering it well with shreds of charpie arranged crosswise, and thoroughly saturated with collodion. The object of the procedure is to exclude the air from the chest, and thereby diminish the chances of suppuration and other untoward occurrences. The histories of the cases in which this method was adopted, during our late war, show, according to Dr. Otis, that it is untrustworthy, only one case having recovered, and in that there was every reason to believe that the symptoms were aggravated by the treatment, and were only relieved by the profuse discharge of pus and blood on the spontaneous opening of the wound.

When a ball, after having perforated the lungs, has lodged under the skin, the best plan is not to disturb it until the wound in the wall of the chest is healed, otherwise it may greatly increase the chances of inflammation. The only exception to this rule is where the injury is complicated with a comminuted fracture of the ribs, sternum, or vertebrae, requiring extraction of large splinters of bone.

Collapse of the lung, partial or complete, is sometimes produced by an accumulation of blood within the chest, occurring immediately after the receipt of the injury. Should this be found to have proceeded from one of the intercostal arteries, the proper remedy will be the ligature, after which the blood may either be removed mechanically, or be permitted to drain off spontaneously, by making the patient lie upon the affected side, so as to render the wound, if possible, the most dependent part of the body. If, on the other hand, it is evident that it has been derived from the lung itself, the best plan will be to let it remain, in the hope that, by compressing the injured structures, it may serve as a hemostatic.

When the lung retains its natural position within the chest, the inflammation consequent upon the injury soon causes it to adhere to the edges of the wound, and, in this manner, all communication between the exterior and the pleural cavity is generally speedily cut off; an occurrence which is one of the greatest safeguards that can possibly happen in such a case, and which should always, if practicable be promoted by making the patient lie upon the affected side. If, on the other hand, the lung is collapsed, it may be so tied down by effused blood and inflammatory deposits as never to regain its original situation.

To avert and moderate inflammation of the lungs and pleuræ in wounds of the chest is one of the great objects of treatment, as this constitutes the chief source of danger when the patient survives the immediate effects of the injury. The principal agents for accomplishing this are the lancet, tartar emetic and opium, purgatives, cupping, and counter-irritants, especially epispastics. If the system has not been too much drained of blood by the accident, the bleeding should be both early and free, and repeated at short intervals until a decided impression has been made upon the disease; otherwise our chief reliance should be upon the use of tartrate of antimony and potassa, in union with anodynes, to allay pain and cough, and promote sleep. For controlling the circulation liberal use should also be made of veratrum viride, its effects being carefully watched, lest too much cardiac depression should arise. The bowels should be thoroughly moved with senna and sulphate of magnesia, or calomel and jalap; blood should be taken by cups or leeches from the chest, over the seat of the morbid action; and, if these remedies do not prove speedily successful, a large blister should be applied, and retained until complete vesication is

produced. Many of these cases, however, either do not bear these depletory measures at all, or only to a very limited extent, and on this account not a little judgment is often required to determine when to employ or to reject them. Perhaps the best guide, in such an event, is the state of the pulse and of the countenance; when the former is hard, full, and frequent, and the latter hot and flushed, lowering agents are plainly indicated, whereas, if the reverse be true, they should be refrained from, tonics and stimulants being used in their stead. Sometimes a kind of middle course is the most judicious.

Penetrating wounds of the chest are extremely liable to be followed by serous, sero-sanguinolent, and purulent effusions, no matter what means may be adopted for their prevention. If the accumulation be trifling, it will generally disappear spontaneously, or under the influence of suitable local and constitutional remedies, as in ordinary pleurisy, or pleuro-pneumonia; but when it is abundant, means must be adopted for its removal, otherwise the patient will be extremely apt to perish. I have seen several cases of death simply from neglect of this precaution. The presence of fluid is denoted by the ordinary symptoms of thoracic effusion, of which absence of the respiratory murmur, dullness on percussion, excessive dyspnoea, harassing cough, and inability to lie on the sound side, are the most prominent and characteristic. If the accumulation is very great, there will be, in addition, partial effacement, and, perhaps, even bulging of the intercostal spaces, thus imparting greater certainty to the diagnosis. All doubt, of course, vanishes if the fluid escapes at the external wound. The formation of pus is generally preceded and accompanied by rigors and hectic irritation.

The proper treatment of this accident is sufficiently obvious. If the external wound has not yet closed, the body is placed in such a position as to render that the most dependent part, and it is seldom that any other procedure will be necessary. In a case under my charge, in which the chest had been penetrated by a pistol ball, evacuation of the cavity could only be effected by placing the patient on his knees and elbows, at the same time raising the hips and lowering the head, thus making the orifice as dependent as possible, an operation which was repeated, for several weeks, at least three times in the twenty-four hours. He ultimately made an excellent recovery, with a collapsed lung. Before this expedient was resorted to, the fluid was occasionally drawn off with a syringe. When no opening exists, or when it cannot be made available for the purpose in question, a new one should be made, care being taken to select the most suitable part of the chest for furnishing a ready outlet to the pent-up fluid, and to avoid injury to the intercostal arteries. Patency of the orifice is maintained by a proper tent, or canula, well secured to the side of the chest, lest it should slip into its cavity.

Injuries of the lungs not unfrequently exert a very prejudicial secondary effect upon these organs, eventuating in the production of abscess, or the development of phthisis, the latter being more likely to take place when there is a hereditary tendency to this disease. Such occurrences cannot always be avoided, but the fact that they may happen should be borne in mind by the surgical attendant, as this will be one of the surest means of preventing them.

Although balls and other foreign bodies, lodged in the lungs, occasionally become encysted, yet in the great majority of cases they ultimately produce extensive and fatal disorganization of the pulmonary structures. The time at which this result occurs is very variable. In a case reported by Boyer the ball was retained for twenty years. A man, aged thirty-five, shot at the battle of Novi, died at the end of seven years, the bullet being found near the base of the left lung, in a distinct membrane, surrounded by indurated tissue. His health, after he had recovered from the more immediate effects of his wound, remained tolerably good for four years, when he was seized with an increase of dyspnoea, nocturnal cough, and hectic irritation, with pain in the chest, and inability to lie on the right side. He had no other sign of pulmonary disease, but finally died completely exhausted. In a case related by Dr. M. H. Houston, a piece of coarse domestic linen, evidently the patch of a bullet, about two inches and a half in length by two in width, when unrolled, was found in the left lung, twenty-five years after its introduction. The cavity in which it lay was opposite the fifth intercostal space, near the spinal column; it was lined by a smooth, tough membrane, and communicated with several of the bronchial tubes, into one of which the foreign substance projected, thus keeping up the cough and irritation which had so long annoyed the patient. The ball, along with a piece

of rib, had been extracted immediately after the receipt of the injury. In the chapter on gunshot wounds, allusion is made to a case where an ounce bullet was found in the right lung, in a distinct cyst, forty-five years after its introduction. In a few fortunate instances, the foreign body was ejected during a violent paroxysm of coughing, excited by its presence, as in the case of a soldier, reported by Dr. Geiger, of Ohio. A Minié ball, weighing three-fourths of an ounce, had entered the chest at the lower margin of the seventh rib, and lodged in the lung, from which it was expelled by the mouth nearly three years after the accident, the man making an excellent recovery. Arnott found a piece of iron hoop in the lung fourteen years after its entrance.

Penetrating wounds of the thorax occasionally remain *fistulous* for an almost indefinite period. Such an event will almost certainly arise when the pulmonary and costal pleuræ fail to adhere for some distance around the more dependent parts of the external orifice, thereby forming a kind of pouch, in which the matter, furnished by the sac, is allowed to accumulate instead of passing off as fast as it is poured out. The manner in which the pouch is usually emptied is by the patient placing himself in a particular posture favorable to the escape of its contents; but as this is often irksome and inadequate, it is seldom that the case receives the requisite attention, and hence many years often elapse before a cure is finally effected. The proper remedy is a counter-opening, made at the most dependent portion of the sac, so as to admit of ready drainage, both during recumbency and in the erect posture, the puncture being prevented from closing by a tent or canula. In a case that was under my care, some years ago, I pierced the chest through the fifth intercostal space, directly over the pericardium, on account of an abscess from a wound with a hatchet between the second and third ribs, and soon succeeded in effecting obliteration of the adventitious cavity. In a second case, as seen in fig. 321, I excised a portion of rib two inches long, and inserted a silver canula to afford an outlet for an abscess, the result of gunshot injury received twenty years previously. The cure of these affections, which is generally followed by a remarkable retrocession of the wall of the chest, is sometimes promoted by weak astringent and detergent injections.

Another unpleasant secondary effect of wounds of the chest is *necrosis* of the ribs and sternum, the exfoliation of which is generally a work of time and suffering, months not unfrequently elapsing before complete riddance can be effected of the disease. The existence of the lesion is usually indicated by a puffy and painful swelling of the part, by a foul discharge, and by the appearance of one or more cloacæ, leading from the surface to the dead bone below. As soon as the bone is found to be loose, it should be removed.

Cases occur in which, during the progress of gunshot wounds of the chest, fragments of bone, the result of fracture of the ribs, vertebræ, or sternum, either alone, or in union with portions of the patient's dress, are coughed up. Such instances are uncommon, and they are by no means always followed by recovery.

Secondary hemorrhage in wounds of the lungs sometimes arises at a very remote period, owing, apparently, to the imperfect cicatrization of the affected tissues. Under such circumstances, indeed, any severe bodily exertion, as lifting a heavy weight, sneezing, laughing, loud talking, or straining at the water-closet, may reopen the vessels, and cause extravasation of blood. A case has been reported, in which a soldier died instantly of internal hemorrhage, brought on by throwing a ball in

Fig. 321.



a game of nine-pins, two months after he had, as was supposed, perfectly recovered from a wound of one of the lungs.

SECT. II.—HEMOTHORAX.

The hemorrhage which succeeds wounds of the chest, constituting what is called hemothorax, may proceed either from the lung, or from some artery in the wall of the thorax, as an intercostal, or a branch of the internal mammary; not unfrequently it is derived from both sources. The quantity of blood poured out varies from a few ounces to several quarts, and hence its effects upon the lung and system may either be very slight or exceedingly severe; perhaps, in the latter case, causing death by exhaustion within a few minutes after the accident, or putting life in jeopardy, at a more remote period, by inflammation and various deposits.

The symptoms which characterize intrathoracic hemorrhage are such as denote loss of blood in other parts of the body, with the superaddition of respiratory embarrassment occasioned by the mechanical compression of the lung. The countenance is deadly pale, the pulse small, quick, and tremulous, the surface cold and clammy, the breathing oppressed, the head giddy, the mind anxious. Thirst and restlessness generally exist in a high degree; the patient experiences a sense of weight in the chest, and is unable to lie on the sound side; the thoracic walls emit a dull sound on percussion; and, if the effusion is large, there will be complete absence of vesicular murmur, with a tendency to flattening of the intercostal spaces. Blood usually escapes at the external wound, and, in the event of injury of the pulmonary tissue, is also discharged by the mouth, either in a pure state, or mixed with frothy mucus. Hemoptysis, however, is not always present in penetrating wounds of the lung. I have seen a number of cases where it was entirely wanting.

When blood escapes from the chest into the subcutaneous cellular tissue along the spine, it is apt to gravitate towards the loins, giving rise to an ecchymotic appearance of that region, which some, as Valentin, Larrey, Louis, and others, have been led to regard as pathognomonic of hemothorax, or effusion of blood into the pleural sac. This statement, however, must be received with some allowance; for it has been shown, on the one hand, that this phenomenon is often entirely wanting in hemorrhage of the chest, and, on the other, that it may be present simply as a consequence of a bruise or contusion, when there has been no injury of this cavity.

The manner in which the blood in hemothorax is disposed of is subject to some diversity; when the quantity is small, it is generally absorbed, followed, probably, by some adhesive action of the pleura; if, however, the quantity is large, it will not only violently compress the lung, but, assuming the solid form, be sure to excite severe inflammation, eventuating in serous and other effusions, which thus greatly complicate and aggravate the original difficulty. Instances occur in which, along with the extravasated blood, there is a considerable accumulation of air, thus combining hemothorax with pneumothorax, and, of course, increasing the urgency of the symptoms and the dangers of the case.

It will thus be perceived that the prognosis of intrathoracic hemorrhage is always serious, except in the minor and more unimportant cases. Death may occur within a few minutes after the accident, or the patient may recover from the primary effects, and perish from the secondary, particularly from the mechanical compression of the lung and the irritation which the blood excites by acting as a foreign body.

The *treatment* of this form of hemorrhage is by no means satisfactory, since it is based upon speculation rather than any well-defined principles. The patient should lie on the affected side, and the wound be kept open, unless the escape of blood is so excessive as to threaten serious, if not fatal, exhaustion, in which event it must be promptly closed. The head and shoulders should be elevated, ice applied to the chest, acetate of lead and opium freely given internally, and, if the strength is not too much impaired, blood taken from the arm, to the extent of slight syncope, the operation being repeated as often as there is a decided tendency to overaction and to recurrence of hemorrhage.

When the blood proceeds from the lung, a circumstance, however, which cannot always, or, perhaps, even generally, be ascertained, the most judicious plan, pro-

bably, will be to let it remain, in the hope that it may exert a favorable hemostatic action upon the wounded part; but, as soon as all apprehension is over in regard to a recurrence of the bleeding, as it generally will be in five or six days, the effused fluid should be evacuated by operation, either by enlarging the original wound, or, if this is situated unfavorably, by making a free opening through one of the intercostal spaces at the most dependent portion of the chest, or wherever the results of percussion and auscultation may unite in locating the extravasated substance. The respiratory organs must be incessantly watched, to protect them from harm, the slightest tendency to inflammation being promptly averted with the lancet, tartar emetic, calomel, and opium, along with thorough and early vesication of the chest.

SECT. III.—PNEUMOTHORAX.

Pneumothorax is caused by injury of the substance of the lung, admitting of an escape of air into the pleural cavity, and, in some cases, also into the posterior mediastinum, and thence, by the cervical vessels and nerves, into the subcutaneous cellular tissue of the neck, trunk, and extremities. But in order that the latter occurrence may happen, it is necessary that there should not only be a wound of the lung, but likewise of the costal pleura. When these two conditions coexist, it is easy to perceive how the air in the pulmonary vesicles may, during the expansion of the lung, be forced into the areolar structure beneath the lining membrane of the thoracic cavity, and thus constitute what is denominated emphysema. Collections of air in these situations may be caused by injury inflicted upon the lung through the walls of the chest, especially if the wound is very small, oblique, or valvular, thereby interfering with the outward escape of the fluid; or they may form independently of any external wound, in consequence of the laceration of the pulmonary tissues by a piece of broken rib, or the sudden and violent compression of the lung during a fall of the body from a considerable height, although such an event must be extremely rare.

Emphysema of the cellular tissue of the trunk occasionally occurs without pneumothorax, as when a portion of lung that has become firmly adherent to the wall of the chest has been injured by the end of a broken rib being driven into its substance. In such a case, which is also one of extreme infrequency, the air may readily escape from the wounded organ into the areolar structure beneath the costal pleura, and from thence into that of the trunk and extremities, but cannot obtain access to the thoracic cavity.

The symptoms denotive of pneumothorax are generally of a very decisive nature. Percussion of the chest affords a remarkably resonant, or hollow, drum-like sound, wholly dissimilar from that which is elicited in any other disease, and, therefore, of itself characteristic of the presence of air; the vesicular murmur is either much diminished, or entirely absent; the breathing is considerably embarrassed; the voice is feeble; difficulty is experienced in lying on the affected side; and the respiration in the sound lung is puerile.

The symptoms of emphysema are also distinctly marked. The puffy, colorless, and elastic swelling, crackling under pressure, and commencing at a particular part of the chest, either at the wound, or, if there is none, opposite a broken rib, and gradually spreading in different directions, is an unmistakable sign of the existence of air beneath the integument. The air, in consequence of the permeable nature of the structure in which it is lodged, may readily be pushed from one place to another, especially soon after it begins to make its appearance; and occasionally travels with astonishing rapidity over the greater portion of

Fig. 322.



General Emphysema of the Whole Surface, after Wound of the Right Side of the Chest.

the body, destroying all distinction of the chest, neck, and face, and thus inducing the most unseemly and frightful deformity, as seen in fig. 322.

The treatment of pneumothorax and emphysema is very simple. In general, the air in the pleural cavity will be rapidly decomposed and absorbed; should it prove troublesome, by causing serious respiratory difficulty, it may be let out slowly by means of a delicate trocar, introduced so as to make a valve-like aperture, which should be closed immediately after with adhesive strips, supported by a compress and bandage. Emphysema is usually easily controlled by compression; but if it should threaten to become very extensive and inconvenient, or, if it actually be so when advice is demanded, the most prompt and effectual remedy will be a moderately free incision at the seat of injury, or a number of little punctures in different parts of the body.

SECT. IV.—HYDROTHORAX AND PYOTHORAX.

Under these names may be described those collections of serum and of pus which supervene upon acute and chronic pleurisy, whether the result of accident or of disease. Collections of this kind are extremely common, and are of great surgical interest, from the fact that they may generally be removed by a very simple and safe operation.

In acute pleurisy, large quantities of serum are frequently poured out in an astonishingly short time, especially when the disease is of great extent and of unusual violence. The fluid is generally thin, colorless, and intermixed with lymph; sometimes it is of a reddish hue, from the presence of hematin, while at other times it is found to be remarkably yellowish, and of a thick, viscid consistence, not unlike copal varnish or fresh olive oil.

It is very seldom that genuine pus is poured out in acute pleuritis, yet such cases are sometimes met with, and that, too, at an early period of the disease. I have seen several instances, chiefly in young, plethoric children, in which one of the thoracic cavities was literally filled with purulent fluid in less than a fortnight from the commencement of the disease.

The water in chronic pleuritis is generally much more abundant than in the acute disease, often amounting to a number of quarts, if not to several gallons. It is also more thick and turbid than in acute attacks, being usually of a light lemon color, and of a somewhat oleaginous consistence. Sometimes it is of a greenish or reddish hue, and cases occur in which it contains blood and pus. The fluid, when drawn off, and allowed to stand for some time, generally separates into two parts; one, thin and viscid, like serum, occupying the top; the other, which consists of fragments of lymph and albumen, resting at the bottom. This disunion not unfrequently takes place during the sojourn of the fluid in the cavity of the chest.

Large portions of lymph are often intermixed with this fluid; and instances are met with in which it consists almost entirely of pure pus. When this is the case, the fluid is generally more or less fetid; sometimes, indeed, almost insupportably so. The quantity of pus is occasionally enormous, amounting, perhaps, to several gallons. When the disease is of long standing, the matter may be partly contained in separate cavities among the layers of adventitious membranes which are so liable to form under such circumstances. I have repeatedly met with cases of chronic pleurisy in which three or four such cavities existed; some being filled with pus, some with serum, and some with a mixture of these fluids and of blood. Old thoracic accumulations occasionally contain gas and various kinds of concretions, especially fibrous and fibro-cartilaginous.

The effects which these various effusions exert upon the lung are generally very distressing, if not most disastrous, compressing and condensing its substance, so as to render it unfit for the purposes of respiration. When the quantity of fluid is very great, the organ is sometimes reduced to a mere cake-like mass, hardly as large as the hand, lying in the back part of the chest, by the side of the spinal column. In this condition, it is occasionally bound firmly down by bands of lymph, so that, even if the fluid is ultimately gotten rid of, it remains incapable of expansion. Very frequently, also, especially in protracted cases, the pulmonary tissues become thoroughly solidified, in consequence of the mechanical compression to which they are subjected, thus rendering them hopelessly impervious to the air. The pleura, in

chronic inflammation, is usually very much thickened from interstitial and surfacial deposits, and closely adherent to the surrounding parts.

The diagnosis of these collections is founded mainly upon three circumstances: first, the history of the case; secondly, the changes in the configuration of the thorax; and, lastly, the alterations in the respiratory functions.

1st. The history of the case will show whether the effusion is the result of traumatic or constitutional causes; if the latter, whether the consequence of ordinary pleurisy, pleuro-pneumonia, or tubercular disease; finally, whether the affection is acute or chronic, open or latent.

2d. Whenever the pleuritic effusion is unusually copious, it sensibly encroaches upon the chest, so as to cause a very manifest enlargement of the corresponding side; the intercostal spaces are not only abnormally widened, but perhaps thrust considerably beyond the level of the ribs. The diaphragm is also more or less depressed, and the heart is thrown out of its natural position, either to one side or down towards the stomach. The extent of the dilatation of the chest varies in different cases, but rarely exceeds two inches. The best way of determining it is to measure both sides with a graduated tape, carried from a central point of the sternum, under the mamma, to the spinous process of the corresponding vertebra. The eye alone, however, is often quite sufficient to detect the difference, even although it be comparatively slight. When the intercostal spaces are much distended, and there is at the same time great wasting of the tissues, fluctuation may occasionally be detected.

3d. The effects exerted by these effusions upon the respiratory sounds and movements are generally of an unmistakable character. The alteration of the vesicular murmur is always in direct ratio to the quantity of fluid, being deep and feeble when it is moderate, but entirely wanting when it is very abundant, except, perhaps, along the spinal column, where it may still be somewhat audible over a space of a few inches in extent. When old adhesions exist between the pulmonary and costal pleuræ, as often happens in the upper part of the chest in tubercular disease, the fluid, unable to compress this portion of the lung, may allow it to receive a certain quantity of air after respiration has ceased everywhere else. No friction sound is ever present when there is much fluid in the chest. To produce such an effect, it is necessary not only that the two pleuræ should be roughened with lymph, but that they should rub more or less against each other. *Ægophony* exists only when the effusion is moderate, or only a few lines in depth; hence, it is not present either in the very early or in the more advanced stages of the disease. Finally, during certain movements of the body, especially if suddenly made, a splashing noise may occasionally be heard within the chest, resembling that produced by agitating a cask partly filled with water.

Dullness on percussion is always present when there is much effusion; commencing at the lower part of the chest, from which it gradually ascends as the fluid mounts upwards, and changing with the position of the patient. This symptom, however, considered by itself, is of no diagnostic value, inasmuch as it always attends solidification of the lungs, in whatever manner induced. When the pleuritic effusion is blended with the extrication of gas, percussion elicits a remarkably clear, tympanitic sound.

The most important functional symptoms, especially in chronic pleuritic effusions, are hectic fever, rapid emaciation, pain in the chest, troublesome cough, a sense of tightness and oppression, great dyspnoea in ascending a flight of stairs, and inability to observe recumbency. If the patient lies down at all, he lies on the affected side, on his back, or in an intermediate posture.

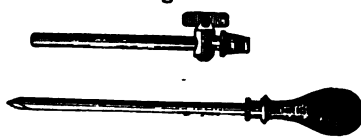
Collections of water, or of water and pus, in the pleural cavity, occasionally find their way out to the external surface; generally through one of the intercostal spaces, as in two cases which have been kindly shown to me by Dr. Da Costa. Sometimes the discharge takes place through the bronchial tubes. Le Dran, Andral, and others have recorded instances in which it was evacuated through the diaphragm. When the patient survives such an event, the track is lined by false membrane, and often remains fistulous for a long time.

But a spontaneous opening is a rare occurrence; and hence, as the fluid, when existing in large quantity, cannot be rendered amenable to the absorbents, the only remedy is to evacuate it by operation, otherwise it will inevitably destroy the patient. Paracentesis of the chest, although occasionally performed by some of the older sur-

geons, was not placed in its true light until within the last twenty years. In this country, attention was first prominently directed to the subject by Dr. Bowditch, of Boston, in a series of papers which have honorably associated his name with this department of pathology and practice. From the results of his cases and of those of other observers, it is evident that the operation, when properly performed, is not only perfectly safe, but generally eminently successful, the issue being always more favorable, other things being equal, in proportion to the shortness of the time that has elapsed since the commencement of the disease, the excellence of the general health, and the absence of purulent matter. When the patient is much exhausted from protracted suffering and serious organic disease, the chances of recovery will, of course, be much lessened.

The operation of tapping the chest, technically called *paracentesis*, is very simple. The instruments which are required are a scalpel and a long, slender trocar, furnished

Fig. 323.



Trocar for Tapping the Chest.

with a stopcock, fig. 323, to prevent the entrance of air into the serous sac. The patient being comfortably propped up in bed, a small incision is made through the integument, previously rendered tense, just above the upper margin of one of the ribs, generally the sixth, about midway between the sternum and spine, or just posterior to the digitations of the great serrated muscle.

When the fluid points externally, the puncture is made at the most prominent and dependent portion of the swelling. The trocar is then thrust boldly through the intercostal space, penetrating the muscles and pleura, as well as any false membranes that may be adherent to its surface. The trocar being now withdrawn, the fluid will come away in a full stream, a suitable vessel having been provided for its reception. A large gum-elastic bag or beef's bladder, secured by a nozzle to the extremity of the canula, will be found to be the most eligible article for the purpose. When it is filled, the stopcock is shut until the bag can be reattached, and thus the operation is continued until the cavity is completely emptied. Upon withdrawing the canula, the integument immediately resumes its natural position, and thus effectually occludes the puncture. The edges of the outer wound are approximated by an adhesive strip, which is the only dressing required, the bandage being objectionable on account of its constricting effects.

The flow of the fluid is sometimes impeded by flakes of solid matter and by the presence of false membrane, necessitating, in the former case, the use of the probe, and in the latter the reintroduction of the trocar. Thorough evacuation is sometimes greatly facilitated by the employment of the gum elastic catheter. Change of posture, coughing, a full inspiration, and straining, as if at stool, often greatly promote evacuation.

The operation is generally well borne, especially if the patient is slightly under the influence of chloroform, which also, in great measure, prevents the cough that is otherwise so apt to attend it. If the patient becomes faint, his head should be gradually lowered, and free use made of brandy. The former of these precautions will usually be required anyhow, with a view to complete clearance of the chest. As the fluid flows off, the lung, if not adherent or solidified, steadily expands, and at length regains its natural volume. If the accumulation has been very great, the operation will probably be obliged to be repeated several times before a final cure can be effected. The after-treatment is very simple; opium is given to allay cough and pain, and the system is supported by good diet and milk punch. When the case is very tedious, the fluid manifesting a strong tendency to reaccumulate rapidly after each operation, the cure may be expedited by the use of a silver tube provided with a proper lid and by the occasional injection of some slightly stimulating lotion, or simple tepid water, and the daily application of dilute tincture of iodine to the walls of the chest, which is generally preferable to a blister.

When a spontaneous opening arises in the chest in empyema, it will generally be found to be altogether inadequate for effectual drainage, both on account of its small size and its vicious site. When this is the case, a counter-opening, or a puncture in some more eligible situation, should be made; for it is very desirable, in every instance of the kind, that the matter should have an opportunity of escaping as fast as it is formed. A similar procedure may occasionally be required after the operation of tapping. The use of the drainage-tube has lately been recommended under

such circumstances, but the treatment, it seems to me, should not be encouraged, as it is both harsh and dangerous.

Paracentesis of the chest is sometimes attended with injury to the lung, the point of the instrument being thrust into its substance. Such an accident, which, however, is seldom followed by serious consequences, will be most liable to occur when the organ has contracted firm adhesions. The intercostal artery is easily avoided by making the puncture in the lower part of the intercostal space, at a considerable distance from the inferior margin of the upper rib. Much outcry has been made about the risk of the entrance of air during the operation, but I am not aware of any case that has proved fatal, or that has led to any serious detriment from this cause.

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Dr. Bowditch, in a communication with which he kindly favored me in 1858, states that he had, up to that time, tapped 72 persons, making in all 125 punctures; but he did not mention the relative number of recoveries and deaths. In every case, marked relief had followed the operation. The ages of the cases ranged from four years to seventy-six.

Finally, the removal of the fluid from the pleural cavity, whether by medicine or operation, is always followed, especially in cases of empyema, by a remarkable contraction of the corresponding side of the chest, which generally remains during life, except when the patient is very young, and the lung regains its full expansion, when it sometimes nearly entirely disappears.

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For the relief of this affection, La Martinière proposed tapping the sternum; but such an operation could only be justifiable when the abscess has been caused by caries, necrosis, or fracture of this bone, and then, of course, there should be no hesitation about its performance. Ordinarily, the surgeon waits until the matter points, when evacuation is effected with the lancet. Trephining of the sternum might be required for the removal of a foreign body in the anterior mediastinum.

SECT. V.—WOUNDS OF THE HEART, PERICARDIUM, AND LARGE VESSELS.

Wounds of the heart may be of an incised, punctured, or gunshot nature, according to the character of the vulnerating body; and their gravity is generally such as to lead very speedily to fatal results. Severe lesions are sometimes inflicted upon this organ without any serious injury of the integument, or any solution whatever

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Wounds of the heart may be limited to the walls of the organ, penetrate its cavities, or affect its partitions. In the first case, they may be said to be superficial; in the other two, deep, and, consequently, of a more serious character. Experience has shown that those parts of the organ which are least protected by the sternum and ribs are those which are most liable to be injured. Of 401 cases, analyzed by Dr. George Fischer, the right ventricle suffered in 123, the left in 101; the right auricle in 28, the left auricle in 13; the apex in 17; the base in 2; the interventricular septum in 7; both ventricles in 26; the entire heart in 16; the right heart in 4; the left heart in 5, and the coronary artery in 2. In 57 cases, the locality of the wound was uncertain.

In *gunshot* wounds of the heart, the ball may lodge in the walls of the organ, or in the interventricular septum, as in the interesting case related by Professor Carnochan. At other times, but this, also, is extremely rare, it may penetrate one of the cavities of the heart, and then fall into the inferior cava, descending, perhaps, nearly as far as the bifurcation of that vessel. Of this occurrence, a remarkable example is afforded by the unique case reported by Dr. Simmons, of a young man who, after having received a pistol-shot in his chest, died at the end of ninety-seven hours, without having given any evidence whatever of being wounded in the heart. Upon dissection, however, an opening, pretty firmly closed by blood and plasma, was discovered in the upper part of the right ventricle, the inner surface of which exhibited a lacerated appearance, but no appreciable lesion existed in any other portion of the organ, and it was only by accident that the ball was detected in the inferior cava.

In this class of wounds, the heart is occasionally fatally injured without any apparent lesion of the walls of the chest. At the last siege of Antwerp by the French, a number of cases occurred in which this viscus was severely contused and ruptured, and yet the closest scrutiny failed to detect any external evidence of the mischief. In some of these cases, death happened instantaneously, while in others it was preceded by violent pneumonia, or by a copious effusion of blood into the pleural sac. Professor Holmes, of Montreal, has recorded a curious instance in which the right ventricle of a young man contained a transverse linear opening, large enough to admit the finger, without any wound in the pericardium, leading to the inference that this membrane had been driven before the ball into the heart, while the latter was forcibly distended. The ball was found loose in the cavity of the chest. Several similar examples have been observed by other practitioners.

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The *symptoms* of wounds of the heart are often so obscure as to be of very doubtful diagnostic value. In general, they are such as indicate severe shock, whether from mere nervous depression or from loss of blood, which is often exceedingly profuse. The patient is faint, anxious, and deadly pale; the pulse is small, frequent, and irregular; the surface is cold and clammy; the pupils are dilated; the voice is feeble and indistinct; and the respiration is laborious, and often interrupted by sighs. The pain is usually very severe, especially in the region of the sternum; and, upon applying the ear to the heart, a peculiar noise is perceived, similar to that which is heard in aneurismal varix, or during the passage of blood from an artery to a vein. Although the patient is usually very much exhausted by the shock consequent upon a wound of this organ, cases not unfrequently occur in which he is able to walk or run a considerable distance before he falls down or expires.

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patient is in the condition above described, there will be strong reason for concluding that the heart has been laid open, especially if the external wound has pierced the pleura. Probing, in such cases, can be of no use in any respect, and should, therefore, be avoided.

The *prognosis* of wounds of the heart is generally, although not invariably, unfavorable. Much will depend, in every case, upon the nature of the injury, especially its extent and direction. Sometimes a single shot is sufficient to cause death almost instantaneously, as happened in the case of a youth, seventeen years of age, from whom the accompanying sketch, fig. 324, was taken, and who was hit in the chest by a stray shot, passing through the left ventricle, near its middle. When a ball or knife takes an oblique, tortuous course among the muscular fibres of the heart, their contraction may be such as to close the track made by the vulnerating body until a clot is formed, and so oppose, in great measure, the effusion of blood, thereby affording the wound an opportunity of undergoing repair. However this may be, there are numerous instances upon record which serve to prove that recovery is by no means impossible. Thus, Dr. Randall, of Tennessee, has reported the case of a negro boy, who died sixty-seven days after having been wounded in the chest with a load of shot. The lesion was followed by severe inflammation of the lungs, but there was no indication that the heart had been injured, and the lad was thought to be convalescent, when he suddenly died from over-indulgence in eating. Upon dissection, five shot were found in the heart, three in the base of the ventricle, and two in the bottom of the auricle; the wounds in the walls of the organ were all firmly healed, and the surfaces of its cavities exhibited no trace of former suffering. In the case of a soldier, mentioned by Fournier, a musket ball was discovered in the right ventricle of the heart, in contact with its septum, six years after he had been shot. Dr. Balch found a ball in the lower part of the wall of the right ventricle of a man eighteen years after he had been wounded. He recovered from the immediate effects of the injury in six weeks. In the case of Poole, recorded by Dr. Carnochan, the probability is that recovery would have taken place if the man had been more careful of himself, and had not been otherwise hurt. He died eleven days after the accident; and the dissection showed that the bullet, which was one-third of an inch in diameter, was enveloped in a delicate cyst, as it lay firmly imbedded in the muscular septum, midway between the apex and base of the ventricles, a quarter of an inch beneath the surface. The cause of death was inflammation of the heart and pericardium, the latter of which was so enormously distended with sero-sanguinolent fluid as to encroach greatly upon both lungs.

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Fig. 324.

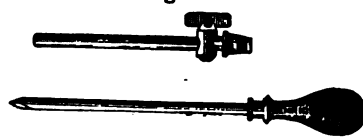


Shot Wound of the Heart.

geons, was not placed in its true light until within the last twenty years. In this country, attention was first prominently directed to the subject by Dr. Bowditch, of Boston, in a series of papers which have honorably associated his name with this department of pathology and practice. From the results of his cases and of those of other observers, it is evident that the operation, when properly performed, is not only perfectly safe, but generally eminently successful, the issue being always more favorable, other things being equal, in proportion to the shortness of the time that has elapsed since the commencement of the disease, the excellence of the general health, and the absence of purulent matter. When the patient is much exhausted from protracted suffering and serious organic disease, the chances of recovery will, of course, be much lessened.

The operation of tapping the chest, technically called *paracentesis*, is very simple. The instruments which are required are a scalpel and a long, slender trocar, furnished

Fig. 323.



Trocar for Tapping the Chest.

with a stopcock, fig. 323, to prevent the entrance of air into the serous sac. The patient being comfortably propped up in bed, a small incision is made through the integument, previously rendered tense, just above the upper margin of one of the ribs, generally the sixth, about midway between the sternum and spine, or just posterior to the digitations of the great serrated muscle.

When the fluid points externally, the puncture is made at the most prominent and dependent portion of the swelling. The trocar is then thrust boldly through the intercostal space, penetrating the muscles and pleura, as well as any false membranes that may be adherent to its surface. The trocar being now withdrawn, the fluid will come away in a full stream, a suitable vessel having been provided for its reception. A large gum-elastic bag or beef's bladder, secured by a nozzle to the extremity of the canula, will be found to be the most eligible article for the purpose. When it is filled, the stopcock is shut until the bag can be reattached, and thus the operation is continued until the cavity is completely emptied. Upon withdrawing the canula, the integument immediately resumes its natural position, and thus effectually occludes the puncture. The edges of the outer wound are approximated by an adhesive strip, which is the only dressing required, the bandage being objectionable on account of its constricting effects.

The flow of the fluid is sometimes impeded by flakes of solid matter and by the presence of false membrane, necessitating, in the former case, the use of the probe, and in the latter the reintroduction of the trocar. Thorough evacuation is sometimes greatly facilitated by the employment of the gum elastic catheter. Change of posture, coughing, a full inspiration, and straining, as if at stool, often greatly promote evacuation.

The operation is generally well borne, especially if the patient is slightly under the influence of chloroform, which also, in great measure, prevents the cough that is otherwise so apt to attend it. If the patient becomes faint, his head should be gradually lowered, and free use made of brandy. The former of these precautions will usually be required anyhow, with a view to complete clearance of the chest. As the fluid flows off, the lung, if not adherent or solidified, steadily expands, and at length regains its natural volume. If the accumulation has been very great, the operation will probably be obliged to be repeated several times before a final cure can be effected. The after-treatment is very simple; opium is given to allay cough and pain, and the system is supported by good diet and milk punch. When the case is very tedious, the fluid manifesting a strong tendency to reaccumulate rapidly after each operation, the cure may be expedited by the use of a silver tube provided with a proper lid and by the occasional injection of some slightly stimulating lotion, or simple tepid water, and the daily application of dilute tincture of iodine to the walls of the chest, which is generally preferable to a blister.

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Fig. 324.



Shot Wound of the Heart.

The cause of death in wounds of the heart is hemorrhage, shock, or compression of the heart by effusion of blood within the pericardium, if it occur soon after the accident, and inflammation and its consequences, if it occur more remotely.

Mere contusion of the heart is occasionally sufficient to destroy life, as in a case mentioned by Nélaton, in which the anterior wall of the right ventricle was bruised and slightly lacerated by a pistol ball, death occurring at the end of twenty-four hours. The ball was found in the pericardium, which was filled with bloody serum.

The *treatment* of wounds of the heart must be conducted upon general principles. If the patient is found to be in a swooning condition, a drink of cold water, with an abundance of cold air, may be allowed, and the head and shoulders should be laid low in order to promote the access of blood to the brain. If the shock is excessive, sinapisms are applied to the spine and extremities, and an injection of turpentine or ammonia given; but all internal stimulants are, if possible, avoided, lest, by favoring untoward reaction, they should increase hemorrhage and the tendency to inflammation. Protracted depression is rather to be desired than avoided. Hence, the treatment, for the first two or three days, should be as much as possible of an expectant nature. Opium should be given largely to relieve pain, which is often very severe, but, above all, to tranquillize the wounded organ, the tumultuous action of which cannot fail to exert a most injurious influence upon the reparative process. It should be combined with aconite and acetate of lead, to augment its sedative influence, and to increase the coagulability of the blood. When inflammation is set up, the chief reliance must be upon the lancet, antimony, calomel, opium, mild purgatives, and revulsives, especially large blisters, with elevation of the head and shoulders. The chest should be supported with a broad flannel bandage; and, after the more acute symptoms have subsided, recourse should be had to small doses of iodide of potassium and bichloride of mercury, to promote the absorption of effused fluids. The patient must take great care of himself during convalescence, as well as for a long time afterwards.

Foreign bodies should be removed, if easily accessible, otherwise they should be permitted to remain, in the hope of becoming encysted, as happened in some of the cases above mentioned, and in many others recorded by different writers.

Wounds of the *pericardium*, uncomplicated with lesion of the heart, are occasionally observed, and their occurrence is probably more frequent than is generally supposed. A number of interesting cases of recovery from such injuries have been reported, their former existence having been satisfactorily established by examination after death, months, if not years, after their infliction. Thus, of 51 cases tabulated by Fischer, 22 recovered, three of which were verified after death from other causes. Of 32 incised wounds, 19 were fatal; of 7 gunshot injuries, only 2 died; of 3 punctured wounds, all perished; and of 9 lacerated and ruptured wounds, 5 died.

Wounds of the pericardium necessarily give rise to inflammation, the presence of which cannot always be recognized by the usual signs of that disease, as the friction sound may be entirely absent in consequence of the interposition of a large quantity of blood between the membrane and the heart. When much fluid exists, whether it be pure blood, or serum, the precordial region will necessarily sound dull on percussion, and often become preternaturally prominent, in the same manner as the thorax in pleuritic effusion. The pulsations of the heart are irregular, tumultuous, and obscure, and the patient finds it difficult, if not impossible, to lie on his back without suffering from swooning, and a sense of impending suffocation. In a case which I saw with Dr. Knapp, auscultation for many days together afforded a peculiar lapping sound, similar to that made by a dog in lapping water, as if the heart had been splashing about in a fluid.

In my private collection is a specimen, kindly presented to me by Dr. J. W. Coles, of the Navy, in which a common sewing needle, nearly two inches in length, is encysted in the pericardium. No history could be obtained of the case, as the man, who was twenty-two years of age, was moribund at the time of his admission into the hospital. An old cicatrice existed on the right side, between the sixth and seventh ribs, immediately exterior to their junction with the cartilages, probably the result of a former attempt at self-destruction. The pericardium was everywhere closely adherent, thus rendering it highly probable that the needle had been introduced a considerable period before death, caused by perforative ulceration of the lower

extremity of the descending colon. In a case tabulated by Dr. Fischer, a ball was encysted in the sac of the pericardium for fifty-two years.

Wounds and ruptures of the pericardium must be managed upon the same general principles as similar injuries of the heart.

Wounds of the *large vessels* of the chest are sufficiently common, and are, perhaps, still more frequently fatal than those of the heart. Their symptoms and treatment require no special attention here.

A rare case of recovery from a stab in the ascending aorta with a knife has been recorded by Dr. Heil. The patient, a Bavarian soldier, died of pneumonia, upwards of a year after the accident, when the wound, which had penetrated all the coats of the vessel, was found to be closed by a firm cicatrice. Guattani and Pelletan each describe an instance in which a wound of the aorta was followed by a false aneurism, the patient of the former surviving the accident several years, of the latter upwards of two months.

No case, so far as I know, of recovery, from wound or rupture of the vena cava has been met with. Blumenbach refers to an instance, observed by Lentin, in which a person lived for many months, although in a very feeble state, after laceration of the thoracic duct.

SECT. VI.—HYDROPERICARDIUM.

Hydropericardium is of surgical interest only in connection with the operation of paracentesis, admissible as a dernier resort, if the accumulation be large, and other treatment be unavailing. The fluid may be strictly serous, or sero-purulent, and varies in quantity from a few ounces to upwards of a gallon. When the inflammation which precedes and accompanies its formation is unusually severe, it is not unfrequently intermixed with flakes of lymph and even pure blood, either liquid or coagulated. The quantity of purulent matter thrown out in chronic pericarditis is sometimes enormous. In a case observed by Dr. Wright, of Baltimore, in a man, thirty-three years of age, it amounted to four quarts.

The diagnosis of this affection, in cases likely to fall into the hands of the surgeon, is, in general, not difficult. Whenever there is a considerable accumulation, whether the result of acute or chronic disease, the precordial region will be found to be dull on percussion, and to be abnormally prominent; not universally, as in pleuritic effusion, but over a circumscribed space of about four or five inches in length by three to four in width. It is seldom that the distension is so copious as to simulate empyema. In a case observed by Dr. Corrigan the projection extended as high up as the first rib, and yet no difficulty was experienced in the diagnosis. Occasionally the fluid can be detected on each side of the sternum and even in the epigastrium. The action of the heart is irregular, tumultuous, obscure, and perceptible beyond the ordinary limits. In general, it is accompanied by a peculiar undulatory or wave-like motion, owing to the fact that some beats are stronger than others. "The impulse," says Hope, "does not accurately coincide with the sound of the ventricular contraction, as the heart has to remove the interposed fluid before it can impinge against the thoracic walls; the first sound is dull and remote, in consequence of the intervention of the fluid; finally, the sensation communicated to the hand and stethoscope is that of an impulse transmitted through a fluid, and not of an organ striking the ribs immediately." When the accumulation is very great and the action of the heart feeble, there may be an entire absence of impulse. If, superadded to these phenomena, there is constant orthopnoea, with frequent paroxysms of swooning, lividity of the countenance, and a feeble, irregular state of the pulse, no reasonable doubt can be entertained respecting the true nature of the disease. Nevertheless, it should not be forgotten that an enormous accumulation may occasionally exist, and yet the patient hardly experience any uneasiness. The affection with which hydropericardium is most liable to be confounded is empyema or hydrothorax. Errors of diagnosis may also arise from encephaloid or lymphoid growths in the mediastinum and from a serous cyst between the lung and the heart.

Paracentesis of the pericardium, originally proposed by Riolanus, in 1653, was first successfully executed by Romero, of Barcelona, in 1819. It may be performed with a trocar of medium size, or, what is, perhaps, in the main preferable, with a bistoury, care being taken, in either case, not to wound the heart or to permit any air to enter

the pleural sac. It will be safest, as a general rule, to select the most prominent portion of the swelling. Camper directs the puncture to be made between the fourth and fifth ribs; Romero, between the fifth and sixth; Desault, between the sixth and seventh. Larrey's advice is to effect penetration between the seventh rib and the ensiform cartilage. Skoda and Schuh each had a case, in one of which the pericardium was pierced through the third intercostal space, and in the other through the fifth. It will thus be seen, not to cite other names, as, for example, those of Senac, Skielderup, and Richerand, that it is impossible to lay down any definite precept as it respects the place of election. My own opinion is that a preliminary incision should be made, of a valve-like character, at the most prominent part of the swelling, within an inch of the sternum, on the left side, and that the distended sac should then be pierced with a trocar of medium size, furnished with a stopcock, to prevent the ingress of air. Great care must be taken not to interfere with the intercostal and internal mammary arteries.

Günther has furnished an analysis of 22 cases of this operation, of which 7 were successful, and of 5 the result was unknown. Of the remainder, 4 died soon after the operation, and the others, after giving promise of improvement, also finally perished. In this country the operation was first performed by Dr. John C. Warren, in 1852. The patient recovered.

SECT. VII.—WOUNDS AND RUPTURE OF THE DIAPHRAGM.

Wounds of this musculo-tendinous septum possess comparatively little practical interest, for not only is their diagnosis extremely difficult, but, even when their nature is ever so well understood, little can be done for their relief. Moreover, they are not only exceedingly dangerous in themselves, but they are often, if, indeed, not generally, complicated with serious lesion of the contents of the chest or abdomen, thus greatly increasing the risk.

Wounds of the diaphragm are generally inflicted with the knife, dirk, sabre, or sword. Their extent is, of course, very variable, and they may be either single or multiple. Occasionally a severe lesion of the diaphragm is produced by the sharp point of a fractured rib, with or without external wound. Gunshot injuries of this septum are sufficiently common in military engagements.

Laceration of the diaphragm is occasionally met with, generally as the result of a severe fall, in which the person, as he alights, receives the blow upon the chest or abdomen, the septum being, perhaps, rendered unusually tense at the moment by a forcible inspiration. The accident may also be caused by the passage of the wheel of a carriage, or by the body being tightly squeezed between two hard and resisting objects, as the buffers of a railway car. In a case, mentioned by Mr. Pollock, the rupture was due to spasmodic contraction in an effort which the man made to save himself from falling.

The left side of the diaphragm suffers incomparably more frequently in this accident than the right, and the fleshy portion than the tendinous. The rent is nearly always longitudinal, or in the direction of the muscular fibres.

The signs of an injury of the diaphragm that is not immediately fatal are generally very equivocal. The most reliable, in a diagnostic point of view, are excessive shock, with great pallor of the countenance, difficulty of respiration, which is performed mainly with the aid of the intercostal muscles, pain in the region of the diaphragm, increased by motion, pressure, and expansion of the chest, intense precordial distress, and irregularity, smallness, and feebleness of the pulse. In some cases the pain extends into the shoulder, along the course of the phrenic nerve. When the shock is conjoined with copious hemorrhage, the sufferer is generally completely collapsed, and often dies without an effort on the part of the system at reaction. The direction of the wound sometimes affords important diagnostic information. When the opening in the diaphragm is capacious, the stomach and even a large portion of the bowel may escape into the chest, thrusting the lung high up into its cavity, and thus proportionately diminishing the size of the abdomen.

The cause of death in wounds and rupture of the diaphragm is usually shock, or shock combined with hemorrhage. An instance has been reported by Mr. Wheelwright, in which a rupture of the diaphragm, caused by a fall from a coach, proved fatal from hemorrhage. The extravasated blood filled the left cavity of the thorax. If the patient survives the immediate effects of the injury, he will be likely to perish

from the resulting inflammation, which often extends far among the neighboring structures. When recovery occurs, the edges of the abnormal opening become gradually rounded off and callous, and the opening itself may, if not very large, be closed by adhesions of the thoracic and abdominal viscera.

Wounds of the diaphragm are liable to be followed by phrenic hernia, attended with protrusion of the stomach, or stomach and bowel, into the thoracic cavity. In a case of extensive rupture of the diaphragm, related by Devergie, in which the stomach and colon were found in the chest, the person survived the accident nine months, and then died of another disease. Death, after such an injury, may occur from strangulation of the displaced viscera at a more or less remote period after its infliction. Thus, in an instance reported by Dr. Smith, in which the diaphragm had been punctured by a sharp-pointed weapon, the man died three months afterwards from strangulation of the protruded stomach.

The treatment of these lesions does not differ, in any respect, from that of injuries of the chest and its contents in general. Reaction is promoted by the usual means; if there is no copious hemorrhage, the external wound is closed with suture and plaster, otherwise it is kept open, the patient lying on the affected side, in order to favor drainage; any tendency to excessive inflammation is counteracted by general and local bleeding, while cough and pain are allayed by anodynes administered in full doses.

CHAPTER XII.

DISEASES AND INJURIES OF THE JAWS, TEETH, AND GUMS.

SECT. I.—AFFECTIONS OF THE SUPERIOR MAXILLARY BONE.

THE superior maxillary bone differs from most of the other pieces of the skeleton, in having a large cavity, denominated the antrum of Highmore. This chamber, which is very diminutive in young subjects, is situated in the body of the bone, and is lined by a reflection of the mucous membrane of the nose, with the middle meatus of which it communicates by an opening, which, in the recent state, hardly equals the volume of a crow quill. Owing to this peculiarity of structure, the diseases of the superior maxillary bone are of a much more complicated character than those of the inferior, although they are, perhaps, not any more frequent. The most important affections of the bone and the chamber of Highmore are wounds, inflammation, abscess, cystic and various kinds of solid tumors, especially the sarcomatous and carcinomatous.

1. *Wounds*.—Wounds of the sinus may be inflicted through the cheek, the alveolar process, the roof of the mouth, or the orbit of the eye; and in their character they may be incised, punctured, or gunshot. The bleeding is always slight, and the treatment of the accident involves no particular principles. Sometimes a wound in this situation is complicated by the presence of a foreign body, which maintains irritation, and impedes the cure. A middle-aged man, a patient of Dr. Donne, of Kentucky, had the antrum perforated with a small dirk-knife. The instrument entered at the orbit, wounding the eye, and breaking off in the cavity of the bone, from which it was extracted more than two years afterwards through the roof of the mouth, its situation being indicated by a black spot a short distance from the first and second molar teeth.

In gunshot wounds of the face, the ball sometimes lodges in the maxillary sinus, as in the cases recorded by Ravaton and Dupuytren. Joubert met with an instance in which a nail was driven, head foremost, into this cavity by a bullet, and Beclard has reported one in which the ferule of an umbrella was firmly implanted in it. All such accidents are necessarily followed by more or less inflammation and discharge, and their true nature can, in general, be determined only by the introduction of a probe along the fistulous openings which accompany them.

When the foreign substance is retained, it must be searched for, and, if possible,

extracted. The same mode of management is necessary when a tooth or fragment of bone is forced into the cavity.

2. *Inflammation*.—Inflammation of the lining membrane of the maxillary sinus is uncommon. It may be developed under the influence of various causes, of which the most frequent are external injury, suppression of the cutaneous perspiration, a syphilitic taint of the system, the inordinate use of mercury, and, above all, the irritation produced by a loose, carious, or necrosed tooth. Occasionally the disease is propagated from the mucous membrane of the nose, by mere continuity of structure. The principal symptoms are pain, of a fixed and severe character, a sense of weight and heat, pulsation, aching of the molar teeth, and, in violent cases, fever. The cheek is often tender on percussion, and the integument sometimes pits on pressure. An increased discharge, of a thin, watery, and fetid nature, from the corresponding nostril, is occasionally present. The pain generally extends to the surrounding structures, as the teeth, nose, orbit, and forehead. The above symptoms, which are always less marked in the chronic than in the acute form of the malady, are not diagnostic, and the practitioner should, therefore, always institute the most thorough examination before he finally decides on their value.

It is of great importance that this disease should be early recognized and properly treated, as its tendency, when neglected or mismanaged, is to run into suppuration and other mischief. Diseased teeth, or stumps of teeth, are, of course, removed, even when it is not very apparent that they are the cause of the inflammation. If the symptoms are severe, blood is taken from the arm, and by leeches from the cheek or the alveolar process; the bowels are freely evacuated with senna and Rochelle salt; and the action of the heart is still further depressed, if necessary, by the exhibition of antimony and diaphoretics, the latter of which are particularly indicated when the inflammation has been induced by cold. Fomentations and the application of steam are often beneficial in assuaging pain and relieving morbid action.

3. *Abscess*.—The formation of abscess in the *antrum* is denoted by an increase of the local and constitutional suffering, described as attending inflammation. The pain becomes more violent, and assumes a throbbing, pulsatile character, darting about in different directions, and being accompanied, in most cases, by a feeling of weight and tightness at the focus of the morbid action. Aching sensations are perceived in the teeth, nose, and frontal sinuses; and there are often severe rigors alternating with flushes of heat. By and by, an erysipelatous blush appears on the cheek; the surface pits on pressure, and is exquisitely painful on the slightest touch. On raising the lip, the gum over the large grinders is found to be abnormally red and tumid, evincing the same increase of disease here as in the other situations. When the natural outlet of the sinus is not obstructed, there is often, especially during recumbency, an escape of pus from the corresponding nostril, which, together with the symptoms just narrated, leaves no doubt respecting the true nature of the complaint.

The matter in this disease is rarely abundant, except in the chronic form, when it may amount to several ounces. It is generally of a thick, cream-like consistence, of a yellowish-green color, and highly fetid, apparently from its long retention. In the more violent grades of the disorder it is often intermixed with flakes of fibrin. In chronic abscess, the lining membrane usually undergoes serious structural changes, becoming thickened, flocculent, and even ulcerated, at the same time that the walls of the antrum are expanded in every direction.

Chronic abscess of the antrum is generally caused by dental irritation, or caries of the jaw-bone. In a very remarkable case, related by Professor Baum, each cavity was distended with purulent matter, from the lodgment of a tooth in its interior. The lining membrane was excessively thickened, but the osseous walls were greatly attenuated, and cracked like parchment under pressure. The patient was a woman, thirty-eight years old, and the disease, which had commenced in early life, had produced horrible deformity of the face.

The treatment of abscess of the antrum is conducted on the same principles as in abscess of the soft parts. The rule is to afford a free outlet to the pent-up fluid; if possible, before the occurrence of serious structural change. Such a step is not neglected even when there is no material obstruction in the natural orifice of the sinus, the insufficiency of this, from its elevated, and, consequently, unfavorable position, being well known. As the abscess is frequently directly dependent upon

the irritation of a decayed tooth, or as some of the teeth are apt to become involved in the disorder, the safest and most expeditious way of affording relief is to extract the affected tooth, the fang of which often projects into the sac of the abscess, and only requires removal in order to let out its contents. Should the opening thus made be inadequate, it may easily be enlarged by means of a trocar, fig. 325, a triangular perforator, or the little drill, fig. 326, constructed upon the principle of a

Fig. 325.



Perforation of the Antrum.

Fig. 326.



Pope's Antrum Drill.

trephine. Patency is carefully maintained until the mucous membrane has regained its normal functions; an occurrence which may often be greatly expedited by the use of mildly astringent injections, and suitable constitutional measures. The tooth usually selected is the middle grinder, especially if it be diseased. When the abscess points at the alveolar process, the puncture may be made there, but with a result much less promising of ultimate success. The site of a tooth that has been long extracted should never be selected for the operation, as the bone at that place is always abnormally solidified.

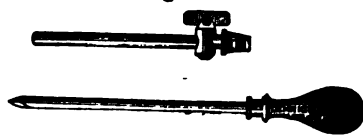
Alveolar abscess may be caused by external violence, by the effects of cold, or by disease of a tooth, and is characterized, at first, by the ordinary phenomena of inflammation, which, as the tendency to suppuration advances, gradually increases in violence, until the suffering becomes almost insupportable. The pain is throbbing or pulsatile, the swelling great, the tenderness exquisite. The matter, usually small in quantity, is excessively fetid, and of a thick, yellowish appearance. Its tendency to point varies. When it is far back, as in the situation of the wisdom tooth, it generally burrows between the bone and muscles, and escapes at the angle of the jaw, preceded and accompanied by great swelling, pain, and constitutional disturbance. In front, in the incisor and canine regions, it insinuates itself between the bone and periosteum of the hard palate, opening, perhaps, at length upon the surface of the soft palate. An abscess at the side of the jaw-bone, along the course of the grinders, may send its contents into the mouth, or evacuate itself through the cheek, face, chin, or upper part of the neck. An abscess connected with the upper incisors sometimes finds an outlet through the nose.

The treatment of an alveolar abscess is by timely and free incision. In the early stage of the disease, leeches, free purgation, and other antiphlogistic means are advisable, with diaphoretic anodynes to allay pain and promote sleep. Lead and opium lotions are preferable, as local applications, to poultices and warm fomentations, which have a tendency to invite the matter to the surface, and thus produce further mischief.

geons, was not placed in its true light until within the last twenty years. In this country, attention was first prominently directed to the subject by Dr. Bowditch, of Boston, in a series of papers which have honorably associated his name with this department of pathology and practice. From the results of his cases and of those of other observers, it is evident that the operation, when properly performed, is not only perfectly safe, but generally eminently successful, the issue being always more favorable, other things being equal, in proportion to the shortness of the time that has elapsed since the commencement of the disease, the excellence of the general health, and the absence of purulent matter. When the patient is much exhausted from protracted suffering and serious organic disease, the chances of recovery will, of course, be much lessened.

The operation of tapping the chest, technically called *paracentesis*, is very simple. The instruments which are required are a scalpel and a long, slender trocar, furnished

Fig. 323.



Trocar for Tapping the Chest.

with a stopcock, fig. 323, to prevent the entrance of air into the serous sac. The patient being comfortably propped up in bed, a small incision is made through the integument, previously rendered tense, just above the upper margin of one of the ribs, generally the sixth, about midway between the sternum and spine, or just posterior to the digitations of the great serrated muscle.

When the fluid points externally, the puncture is made at the most prominent and dependent portion of the swelling. The trocar is then thrust boldly through the intercostal space, penetrating the muscles and pleura, as well as any false membranes that may be adherent to its surface. The trocar being now withdrawn, the fluid will come away in a full stream, a suitable vessel having been provided for its reception. A large gum-elastic bag or beef's bladder, secured by a nozzle to the extremity of the canula, will be found to be the most eligible article for the purpose. When it is filled, the stopcock is shut until the bag can be reattached, and thus the operation is continued until the cavity is completely emptied. Upon withdrawing the canula, the integument immediately resumes its natural position, and thus effectually occludes the puncture. The edges of the outer wound are approximated by an adhesive strip, which is the only dressing required, the bandage being objectionable on account of its constricting effects.

The flow of the fluid is sometimes impeded by flakes of solid matter and by the presence of false membrane, necessitating, in the former case, the use of the probe, and in the latter the reintroduction of the trocar. Thorough evacuation is sometimes greatly facilitated by the employment of the gum elastic catheter. Change of posture, coughing, a full inspiration, and straining, as if at stool, often greatly promote evacuation.

The operation is generally well borne, especially if the patient is slightly under the influence of chloroform, which also, in great measure, prevents the cough that is otherwise so apt to attend it. If the patient becomes faint, his head should be gradually lowered, and free use made of brandy. The former of these precautions will usually be required anyhow, with a view to complete clearance of the chest. As the fluid flows off, the lung, if not adherent or solidified, steadily expands, and at length regains its natural volume. If the accumulation has been very great, the operation will probably be obliged to be repeated several times before a final cure can be effected. The after-treatment is very simple; opium is given to allay cough and pain, and the system is supported by good diet and milk punch. When the case is very tedious, the fluid manifesting a strong tendency to reaccumulate rapidly after each operation, the cure may be expedited by the use of a silver tube provided with a proper lid and by the occasional injection of some slightly stimulating lotion, or simple tepid water, and the daily application of dilute tincture of iodine to the walls of the chest, which is generally preferable to a blister.

When a spontaneous opening arises in the chest in empyema, it will generally be found to be altogether inadequate for effectual drainage, both on account of its small size and its vicious site. When this is the case, a counter-opening, or a puncture in some more eligible situation, should be made; for it is very desirable, in every instance of the kind, that the matter should have an opportunity of escaping as fast as it is formed. A similar procedure may occasionally be required after the operation of tapping. The use of the drainage-tube has lately been recommended under

such circumstances, but the treatment, it seems to me, should not be encouraged, as it is both harsh and dangerous.

Paracentesis of the chest is sometimes attended with injury to the lung, the point of the instrument being thrust into its substance. Such an accident, which, however, is seldom followed by serious consequences, will be most liable to occur when the organ has contracted firm adhesions. The intercostal artery is easily avoided by making the puncture in the lower part of the intercostal space, at a considerable distance from the inferior margin of the upper rib. Much outcry has been made about the risk of the entrance of air during the operation, but I am not aware of any case that has proved fatal, or that has led to any serious detriment from this cause.

Of 498 cases of this operation, collected by Günther, in 1861, 302 were cured, 149 died, 16 were improved, 19 recovered with a fistulous opening, and of 12 the result was unknown. Of 132 cases analyzed by Dr. John A. Brady, of Brooklyn, 79 were cured, 14 were relieved, and 37 ended fatally; in 1 the result was not known, and in 1 no benefit followed. In a number of the patients that died, the disease had committed irremediable ravages before recourse was had to the operation. Of the 37 fatal cases, 11 were carried off by phthisis.

Dr. Bowditch, in a communication with which he kindly favored me in 1858, states that he had, up to that time, tapped 72 persons, making in all 125 punctures; but he did not mention the relative number of recoveries and deaths. In every case, marked relief had followed the operation. The ages of the cases ranged from four years to seventy-six.

Finally, the removal of the fluid from the pleural cavity, whether by medicine or operation, is always followed, especially in cases of empyema, by a remarkable contraction of the corresponding side of the chest, which generally remains during life, except when the patient is very young, and the lung regains its full expansion, when it sometimes nearly entirely disappears.

Tapping of the chest is sometimes rendered necessary on account of the existence of hydatids in the cavity of the pleura, as in the interesting case recorded by Dr. Reginald Southey, of London. The patient, a man, thirty-one years old, had suffered from a variety of anomalous symptoms, somewhat resembling neuralgia and hysteria, attended with cough, dyspnoea, and pain in the chest, when a marked projection appeared on the right side of the spine, extending into the interscapular region. A puncture made with an exploring needle gave vent to a large quantity of puriform fluid, with some relief. Subsequently, a free incision was made between the sixth and seventh ribs, and a soft, loose, jelly-like mass, recognized as a part of a hydatid, was extracted. It was about the size of a pig's bladder, and seemed to have formed in the sac of the pleura, above the diaphragm, without any connection whatever with the liver. A speedy recovery took place.

Collections of pus are liable to form in the *anterior mediastinum*, sometimes as an effect of cold, but more commonly of external injury, as a blow or fall upon the chest, or of fracture, caries, or necrosis of the sternum. The principal symptoms are, severe pain, great tenderness on pressure, and difficulty of respiration with inability to lie down. Violent rigors sometimes attend; and fever, of a remittent or intermittent character, is usually present throughout. The diagnosis must necessarily be obscure. The matter commonly points at an intercostal space by the side of the sternum; occasionally it bursts into the pleural cavity, and then generally induces death by inflammation, pyemia, or hectic irritation.

For the relief of this affection, La Martinière proposed tapping the sternum; but such an operation could only be justifiable when the abscess has been caused by caries, necrosis, or fracture of this bone, and then, of course, there should be no hesitation about its performance. Ordinarily, the surgeon waits until the matter points, when evacuation is effected with the lancet. Trephining of the sternum might be required for the removal of a foreign body in the anterior mediastinum.

SECT. V.—WOUNDS OF THE HEART, PERICARDIUM, AND LARGE VESSELS.

Wounds of the heart may be of an incised, punctured, or gunshot nature, according to the character of the vulnerating body; and their gravity is generally such as to lead very speedily to fatal results. Severe lesions are sometimes inflicted upon this organ without any serious injury of the integument, or any solution whatever

of its continuity, as in fracture of the ribs and sternum, in which some of the fragments are driven into its substance, or so rudely pressed against its surface as to cause more or less contusion.

Wounds of the heart may be limited to the walls of the organ, penetrate its cavities, or affect its partitions. In the first case, they may be said to be superficial; in the other two, deep, and, consequently, of a more serious character. Experience has shown that those parts of the organ which are least protected by the sternum and ribs are those which are most liable to be injured. Of 401 cases, analyzed by Dr. George Fischer, the right ventricle suffered in 123, the left in 101; the right auricle in 28, the left auricle in 13; the apex in 17; the base in 2; the interventricular septum in 7; both ventricles in 26; the entire heart in 16; the right heart in 4; the left heart in 5, and the coronary artery in 2. In 57 cases, the locality of the wound was uncertain.

In *gunshot* wounds of the heart, the ball may lodge in the walls of the organ, or in the interventricular septum, as in the interesting case related by Professor Carnochan. At other times, but this, also, is extremely rare, it may penetrate one of the cavities of the heart, and then fall into the inferior cava, descending, perhaps, nearly as far as the bifurcation of that vessel. Of this occurrence, a remarkable example is afforded by the unique case reported by Dr. Simmons, of a young man who, after having received a pistol-shot in his chest, died at the end of ninety-seven hours, without having given any evidence whatever of being wounded in the heart. Upon dissection, however, an opening, pretty firmly closed by blood and plasma, was discovered in the upper part of the right ventricle, the inner surface of which exhibited a lacerated appearance, but no appreciable lesion existed in any other portion of the organ, and it was only by accident that the ball was detected in the inferior cava.

In this class of wounds, the heart is occasionally fatally injured without any apparent lesion of the walls of the chest. At the last siege of Antwerp by the French, a number of cases occurred in which this viscus was severely contused and ruptured, and yet the closest scrutiny failed to detect any external evidence of the mischief. In some of these cases, death happened instantaneously, while in others it was preceded by violent pneumonia, or by a copious effusion of blood into the pleural sac. Professor Holmes, of Montreal, has recorded a curious instance in which the right ventricle of a young man contained a transverse linear opening, large enough to admit the finger, without any wound in the pericardium, leading to the inference that this membrane had been driven before the ball into the heart, while the latter was forcibly distended. The ball was found loose in the cavity of the chest. Several similar examples have been observed by other practitioners.

Wounds of the heart are often complicated with other injuries, as fractures of the ribs and sternum, and wounds of the lungs, diaphragm, and large vessels.

Of 22 cases of accidental *rupture* of the heart, in which the precise seat of the lesion was noted, analyzed by Mr. Gamgee, 12 occurred on the right side and 10 on the left; 8 of the former affecting the ventricle, and 4 the auricle, while of the latter 3 involved the ventricle, and 7 the auricle. The pericardium in half of the cases was intact. Such an occurrence can only be explained on the assumption that the ventricle was dilated at the moment of the percussion.

The *symptoms* of wounds of the heart are often so obscure as to be of very doubtful diagnostic value. In general, they are such as indicate severe shock, whether from mere nervous depression or from loss of blood, which is often exceedingly profuse. The patient is faint, anxious, and deadly pale; the pulse is small, frequent, and irregular; the surface is cold and clammy; the pupils are dilated; the voice is feeble and indistinct; and the respiration is laborious, and often interrupted by sighs. The pain is usually very severe, especially in the region of the sternum; and, upon applying the ear to the heart, a peculiar noise is perceived, similar to that which is heard in aneurismal varix, or during the passage of blood from an artery to a vein. Although the patient is usually very much exhausted by the shock consequent upon a wound of this organ, cases not unfrequently occur in which he is able to walk or run a considerable distance before he falls down or expires.

These symptoms are, obviously, not pathognomonic; for they may be caused by various other lesions, as a wound of the lungs or large vessels. Important information may often be derived from a consideration of the situation and direction of the wound. Thus, if a knife, sabre, or ball has entered the chest on the left side, between the fourth and fifth ribs, about two inches from the sternum, and the

patient is in the condition above described, there will be strong reason for concluding that the heart has been laid open, especially if the external wound has pierced the pleura. Probing, in such cases, can be of no use in any respect, and should, therefore, be avoided.

The *prognosis* of wounds of the heart is generally, although not invariably, unfavorable. Much will depend, in every case, upon the nature of the injury, especially its extent and direction. Sometimes a single shot is sufficient to cause death almost instantaneously, as happened in the case of a youth, seventeen years of age, from whom the accompanying sketch, fig. 324, was taken, and who was hit in the chest by a stray shot, passing through the left ventricle, near its middle. When a ball or knife takes an oblique, tortuous course among the muscular fibres of the heart, their contraction may be such as to close the track made by the vulnerating body until a clot is formed, and so oppose, in great measure, the effusion of blood, thereby affording the wound an opportunity of undergoing repair. However this may be, there are numerous instances upon record which serve to prove that recovery is by no means impossible. Thus, Dr. Randall, of Tennessee, has reported the case of a negro boy, who died sixty-seven days after having been wounded in the chest with a load of shot. The lesion was followed by severe inflammation of the lungs, but there was no indication that the heart had been injured, and the lad was thought to be convalescent, when he suddenly died from over-indulgence in eating. Upon dissection, five shot were found in the heart, three in the base of the ventricle, and two in the bottom of the auricle; the wounds in the walls of the organ were all firmly healed, and the surfaces of its cavities exhibited no trace of former suffering. In the case of a soldier, mentioned by Fournier, a musket ball was discovered in the right ventricle of the heart, in contact with its septum, six years after he had been shot. Dr. Balch found a ball in the lower part of the wall of the right ventricle of a man eighteen years after he had been wounded. He recovered from the immediate effects of the injury in six weeks. In the case of Poole, recorded by Dr. Carnochan, the probability is that recovery would have taken place if the man had been more careful of himself, and had not been otherwise hurt. He died eleven days after the accident; and the dissection showed that the bullet, which was one-third of an inch in diameter, was enveloped in a delicate cyst, as it lay firmly imbedded in the muscular septum, midway between the apex and base of the ventricles, a quarter of an inch beneath the surface. The cause of death was inflammation of the heart and pericardium, the latter of which was so enormously distended with sero-sanguinolent fluid as to encroach greatly upon both lungs.

Some remarkable instances have been recorded of persons surviving a considerable length of time after the heart had been transfixed by foreign substances. Thus, Ferrus has narrated the particulars of the case of a man who lived for twenty days with a skewer traversing his heart; and Mr. Davis mentions one of a boy who lived upwards of a month with a piece of wood, three inches long, in the right ventricle. Of 30 examples of punctured wounds of this organ, collected by Dr. Purple, of New York, 2 survived twenty-five days. In one of these the injury, inflicted with a penknife, opened the coronary artery, and in the other the heart was pierced at six different places by a saddler's needle.

Of 401 cases tabulated by Dr. Fischer, 103 died immediately; 199 consecutively; 50 recovered, and in 49 the termination is not given; 33 of the recoveries were proved by post-mortem inspection, but in the remainder the wound was only conjectured from the symptoms. Deducting the uncertain cases, of 352 wounds of the heart, 217 were incised, with 30 cures; 51 gunshot, with 7 recoveries, in four of which the balls remained in the organ; 47 lacerated and ruptured, with 3 cures; and 37 punctured, with 10 recoveries. The majority of the incised wounds were made by knives, daggers, and poniards, while four-fifths of the punctured were due to needles.

Fig. 324.



Shot Wound of the Heart.

The cause of death in wounds of the heart is hemorrhage, shock, or compression of the heart by effusion of blood within the pericardium, if it occur soon after the accident, and inflammation and its consequences, if it occur more remotely.

Mere contusion of the heart is occasionally sufficient to destroy life, as in a case mentioned by Nélaton, in which the anterior wall of the right ventricle was bruised and slightly lacerated by a pistol ball, death occurring at the end of twenty-four hours. The ball was found in the pericardium, which was filled with bloody serum.

The treatment of wounds of the heart must be conducted upon general principles. If the patient is found to be in a swooning condition, a drink of cold water, with an abundance of cold air, may be allowed, and the head and shoulders should be laid low in order to promote the access of blood to the brain. If the shock is excessive, sinapisms are applied to the spine and extremities, and an injection of turpentine or ammonia given; but all internal stimulants are, if possible, avoided, lest, by favoring untoward reaction, they should increase hemorrhage and the tendency to inflammation. Protracted depression is rather to be desired than avoided. Hence, the treatment, for the first two or three days, should be as much as possible of an expectant nature. Opium should be given largely to relieve pain, which is often very severe, but, above all, to tranquillize the wounded organ, the tumultuous action of which cannot fail to exert a most injurious influence upon the reparative process. It should be combined with aconite and acetate of lead, to augment its sedative influence, and to increase the coagulability of the blood. When inflammation is set up, the chief reliance must be upon the lancet, antimony, calomel, opium, mild purgatives, and revulsives, especially large blisters, with elevation of the head and shoulders. The chest should be supported with a broad flannel bandage; and, after the more acute symptoms have subsided, recourse should be had to small doses of iodide of potassium and bichloride of mercury, to promote the absorption of effused fluids. The patient must take great care of himself during convalescence, as well as for a long time afterwards.

Foreign bodies should be removed, if easily accessible, otherwise they should be permitted to remain, in the hope of becoming encysted, as happened in some of the cases above mentioned, and in many others recorded by different writers.

Wounds of the *pericardium*, uncomplicated with lesion of the heart, are occasionally observed, and their occurrence is probably more frequent than is generally supposed. A number of interesting cases of recovery from such injuries have been reported, their former existence having been satisfactorily established by examination after death, months, if not years, after their infliction. Thus, of 51 cases tabulated by Fischer, 22 recovered, three of which were verified after death from other causes. Of 32 incised wounds, 19 were fatal; of 7 gunshot injuries, only 2 died; of 3 punctured wounds, all perished; and of 9 lacerated and ruptured wounds, 5 died.

Wounds of the pericardium necessarily give rise to inflammation, the presence of which cannot always be recognized by the usual signs of that disease, as the friction sound may be entirely absent in consequence of the interposition of a large quantity of blood between the membrane and the heart. When much fluid exists, whether it be pure blood, or serum, the precordial region will necessarily sound dull on percussion, and often become preternaturally prominent, in the same manner as the thorax in pleuritic effusion. The pulsations of the heart are irregular, tumultuous, and obscure, and the patient finds it difficult, if not impossible, to lie on his back without suffering from swooning, and a sense of impending suffocation. In a case which I saw with Dr. Knapp, auscultation for many days together afforded a peculiar lapping sound, similar to that made by a dog in lapping water, as if the heart had been splashing about in a fluid.

In my private collection is a specimen, kindly presented to me by Dr. J. W. Coles, of the Navy, in which a common sewing needle, nearly two inches in length, is encysted in the pericardium. No history could be obtained of the case, as the man, who was twenty-two years of age, was moribund at the time of his admission into the hospital. An old cicatrice existed on the right side, between the sixth and seventh ribs, immediately exterior to their junction with the cartilages, probably the result of a former attempt at self-destruction. The pericardium was everywhere closely adherent, thus rendering it highly probable that the needle had been introduced a considerable period before death, caused by perforative ulceration of the lower

extremity of the descending colon. In a case tabulated by Dr. Fischer, a ball was encysted in the sac of the pericardium for fifty-two years.

Wounds and ruptures of the pericardium must be managed upon the same general principles as similar injuries of the heart.

Wounds of the *large vessels* of the chest are sufficiently common, and are, perhaps, still more frequently fatal than those of the heart. Their symptoms and treatment require no special attention here.

A rare case of recovery from a stab in the ascending aorta with a knife has been recorded by Dr. Heil. The patient, a Bavarian soldier, died of pneumonia, upwards of a year after the accident, when the wound, which had penetrated all the coats of the vessel, was found to be closed by a firm cicatrice. Guattani and Pelletan each describe an instance in which a wound of the aorta was followed by a false aneurism, the patient of the former surviving the accident several years, of the latter upwards of two months.

No case, so far as I know, of recovery, from wound or rupture of the vena cava has been met with. Blumenbach refers to an instance, observed by Lentin, in which a person lived for many months, although in a very feeble state, after laceration of the thoracic duct.

SECT. VI.—HYDROPERICARDIUM.

Hydropericardium is of surgical interest only in connection with the operation of paracentesis, admissible as a dernier resort, if the accumulation be large, and other treatment be unavailing. The fluid may be strictly serous, or sero-purulent, and varies in quantity from a few ounces to upwards of a gallon. When the inflammation which precedes and accompanies its formation is unusually severe, it is not unfrequently intermixed with flakes of lymph and even pure blood, either liquid or coagulated. The quantity of purulent matter thrown out in chronic pericarditis is sometimes enormous. In a case observed by Dr. Wright, of Baltimore, in a man, thirty-three years of age, it amounted to four quarts.

The diagnosis of this affection, in cases likely to fall into the hands of the surgeon, is, in general, not difficult. Whenever there is a considerable accumulation, whether the result of acute or chronic disease, the precordial region will be found to be dull on percussion, and to be abnormally prominent; not universally, as in pleuritic effusion, but over a circumscribed space of about four or five inches in length by three to four in width. It is seldom that the distension is so copious as to simulate empyema. In a case observed by Dr. Corrigan the projection extended as high up as the first rib, and yet no difficulty was experienced in the diagnosis. Occasionally the fluid can be detected on each side of the sternum and even in the epigastrium. The action of the heart is irregular, tumultuous, obscure, and perceptible beyond the ordinary limits. In general, it is accompanied by a peculiar undulatory or wave-like motion, owing to the fact that some beats are stronger than others. "The impulse," says Hope, "does not accurately coincide with the sound of the ventricular contraction, as the heart has to remove the interposed fluid before it can impinge against the thoracic walls; the first sound is dull and remote, in consequence of the intervention of the fluid; finally, the sensation communicated to the hand and stethoscope is that of an impulse transmitted through a fluid, and not of an organ striking the ribs immediately." When the accumulation is very great and the action of the heart feeble, there may be an entire absence of impulse. If, superadded to these phenomena, there is constant orthopnoea, with frequent paroxysms of swooning, lividity of the countenance, and a feeble, irregular state of the pulse, no reasonable doubt can be entertained respecting the true nature of the disease. Nevertheless, it should not be forgotten that an enormous accumulation may occasionally exist, and yet the patient hardly experience any uneasiness. The affection with which hydropericardium is most liable to be confounded is empyema or hydrothorax. Errors of diagnosis may also arise from encephaloid or lymphoid growths in the mediastinum and from a serous cyst between the lung and the heart.

Paracentesis of the pericardium, originally proposed by Riolanus, in 1653, was first successfully executed by Romero, of Barcelona, in 1819. It may be performed with a trocar of medium size, or, what is, perhaps, in the main preferable, with a bistoury, care being taken, in either case, not to wound the heart or to permit any air to enter

the pleural sac. It will be safest, as a general rule, to select the most prominent portion of the swelling. Camper directs the puncture to be made between the fourth and fifth ribs; Romero, between the fifth and sixth; Desault, between the sixth and seventh. Larrey's advice is to effect penetration between the seventh rib and the ensiform cartilage. Skoda and Schuh each had a case, in one of which the pericardium was pierced through the third intercostal space, and in the other through the fifth. It will thus be seen, not to cite other names, as, for example, those of Senac, Skielderup, and Richerand, that it is impossible to lay down any definite precept as it respects the place of election. My own opinion is that a preliminary incision should be made, of a valve-like character, at the most prominent part of the swelling, within an inch of the sternum, on the left side, and that the distended sac should then be pierced with a trocar of medium size, furnished with a stopcock, to prevent the ingress of air. Great care must be taken not to interfere with the intercostal and internal mammary arteries.

Günther has furnished an analysis of 22 cases of this operation, of which 7 were successful, and of 5 the result was unknown. Of the remainder, 4 died soon after the operation, and the others, after giving promise of improvement, also finally perished. In this country the operation was first performed by Dr. John C. Warren, in 1852. The patient recovered.

SECT. VII.—WOUNDS AND RUPTURE OF THE DIAPHRAGM.

Wounds of this musculo-tendinous septum possess comparatively little practical interest, for not only is their diagnosis extremely difficult, but, even when their nature is ever so well understood, little can be done for their relief. Moreover, they are not only exceedingly dangerous in themselves, but they are often, if, indeed, not generally, complicated with serious lesion of the contents of the chest or abdomen, thus greatly increasing the risk.

Wounds of the diaphragm are generally inflicted with the knife, dirk, sabre, or sword. Their extent is, of course, very variable, and they may be either single or multiple. Occasionally a severe lesion of the diaphragm is produced by the sharp point of a fractured rib, with or without external wound. Gunshot injuries of this septum are sufficiently common in military engagements.

Laceration of the diaphragm is occasionally met with, generally as the result of a severe fall, in which the person, as he alights, receives the blow upon the chest or abdomen, the septum being, perhaps, rendered unusually tense at the moment by a forcible inspiration. The accident may also be caused by the passage of the wheel of a carriage, or by the body being tightly squeezed between two hard and resisting objects, as the buffers of a railway car. In a case, mentioned by Mr. Pollock, the rupture was due to spasmodic contraction in an effort which the man made to save himself from falling.

The left side of the diaphragm suffers incomparably more frequently in this accident than the right, and the fleshy portion than the tendinous. The rent is nearly always longitudinal, or in the direction of the muscular fibres.

The signs of an injury of the diaphragm that is not immediately fatal are generally very equivocal. The most reliable, in a diagnostic point of view, are excessive shock, with great pallor of the countenance, difficulty of respiration, which is performed mainly with the aid of the intercostal muscles, pain in the region of the diaphragm, increased by motion, pressure, and expansion of the chest, intense precordial distress, and irregularity, smallness, and feebleness of the pulse. In some cases the pain extends into the shoulder, along the course of the phrenic nerve. When the shock is conjoined with copious hemorrhage, the sufferer is generally completely collapsed, and often dies without an effort on the part of the system at reaction. The direction of the wound sometimes affords important diagnostic information. When the opening in the diaphragm is capacious, the stomach and even a large portion of the bowel may escape into the chest, thrusting the lung high up into its cavity, and thus proportionately diminishing the size of the abdomen.

The cause of death in wounds and rupture of the diaphragm is usually shock, or shock combined with hemorrhage. An instance has been reported by Mr. Wheelwright, in which a rupture of the diaphragm, caused by a fall from a coach, proved fatal from hemorrhage. The extravasated blood filled the left cavity of the thorax. If the patient survives the immediate effects of the injury, he will be likely to perish

from the resulting inflammation, which often extends far among the neighboring structures. When recovery occurs, the edges of the abnormal opening become gradually rounded off and callous, and the opening itself may, if not very large, be closed by adhesions of the thoracic and abdominal viscera.

Wounds of the diaphragm are liable to be followed by phrenic hernia, attended with protrusion of the stomach, or stomach and bowel, into the thoracic cavity. In a case of extensive rupture of the diaphragm, related by Devergie, in which the stomach and colon were found in the chest, the person survived the accident nine months, and then died of another disease. Death, after such an injury, may occur from strangulation of the displaced viscera at a more or less remote period after its infliction. Thus, in an instance reported by Dr. Smith, in which the diaphragm had been punctured by a sharp-pointed weapon, the man died three months afterwards from strangulation of the protruded stomach.

The treatment of these lesions does not differ, in any respect, from that of injuries of the chest and its contents in general. Reaction is promoted by the usual means; if there is no copious hemorrhage, the external wound is closed with suture and plaster, otherwise it is kept open, the patient lying on the affected side, in order to favor drainage; any tendency to excessive inflammation is counteracted by general and local bleeding, while cough and pain are allayed by anodynes administered in full doses.

CHAPTER XII.

DISEASES AND INJURIES OF THE JAWS, TEETH, AND GUMS.

SECT. I.—AFFECTIONS OF THE SUPERIOR MAXILLARY BONE.

THE superior maxillary bone differs from most of the other pieces of the skeleton, in having a large cavity, denominated the antrum of Highmore. This chamber, which is very diminutive in young subjects, is situated in the body of the bone, and is lined by a reflection of the mucous membrane of the nose, with the middle meatus of which it communicates by an opening, which, in the recent state, hardly equals the volume of a crow quill. Owing to this peculiarity of structure, the diseases of the superior maxillary bone are of a much more complicated character than those of the inferior, although they are, perhaps, not any more frequent. The most important affections of the bone and the chamber of Highmore are wounds, inflammation, abscess, cystic and various kinds of solid tumors, especially the sarcomatous and carcinomatous.

1. *Wounds.*—Wounds of the sinus may be inflicted through the cheek, the alveolar process, the roof of the mouth, or the orbit of the eye; and in their character they may be incised, punctured, or gunshot. The bleeding is always slight, and the treatment of the accident involves no particular principles. Sometimes a wound in this situation is complicated by the presence of a foreign body, which maintains irritation, and impedes the cure. A middle-aged man, a patient of Dr. Donne, of Kentucky, had the antrum perforated with a small dirk-knife. The instrument entered at the orbit, wounding the eye, and breaking off in the cavity of the bone, from which it was extracted more than two years afterwards through the roof of the mouth, its situation being indicated by a black spot a short distance from the first and second molar teeth.

In gunshot wounds of the face, the ball sometimes lodges in the maxillary sinus, as in the cases recorded by Ravaton and Dupuytren. Joubert met with an instance in which a nail was driven, head foremost, into this cavity by a bullet, and Beclard has reported one in which the ferule of an umbrella was firmly implanted in it. All such accidents are necessarily followed by more or less inflammation and discharge, and their true nature can, in general, be determined only by the introduction of a probe along the fistulous openings which accompany them.

When the foreign substance is retained, it must be searched for, and, if possible,

extracted. The same mode of management is necessary when a tooth or fragment of bone is forced into the cavity.

2. *Inflammation*.—Inflammation of the lining membrane of the maxillary sinus is uncommon. It may be developed under the influence of various causes, of which the most frequent are external injury, suppression of the cutaneous perspiration, a syphilitic taint of the system, the inordinate use of mercury, and, above all, the irritation produced by a loose, carious, or necrosed tooth. Occasionally the disease is propagated from the mucous membrane of the nose, by mere continuity of structure. The principal symptoms are pain, of a fixed and severe character, a sense of weight and heat, pulsation, aching of the molar teeth, and, in violent cases, fever. The cheek is often tender on percussion, and the integument sometimes pits on pressure. An increased discharge, of a thin, watery, and fetid nature, from the corresponding nostril, is occasionally present. The pain generally extends to the surrounding structures, as the teeth, nose, orbit, and forehead. The above symptoms, which are always less marked in the chronic than in the acute form of the malady, are not diagnostic, and the practitioner should, therefore, always institute the most thorough examination before he finally decides on their value.

It is of great importance that this disease should be early recognized and properly treated, as its tendency, when neglected or mismanaged, is to run into suppuration and other mischief. Diseased teeth, or stumps of teeth, are, of course, removed, even when it is not very apparent that they are the cause of the inflammation. If the symptoms are severe, blood is taken from the arm, and by leeches from the cheek or the alveolar process; the bowels are freely evacuated with senna and Rochelle salt; and the action of the heart is still further depressed, if necessary, by the exhibition of antimony and diaphoretics, the latter of which are particularly indicated when the inflammation has been induced by cold. Fomentations and the application of steam are often beneficial in assuaging pain and relieving morbid action.

3. *Abscess*.—The formation of abscess in the *antrum* is denoted by an increase of the local and constitutional suffering, described as attending inflammation. The pain becomes more violent, and assumes a throbbing, pulsatile character, darting about in different directions, and being accompanied, in most cases, by a feeling of weight and tightness at the focus of the morbid action. Aching sensations are perceived in the teeth, nose, and frontal sinuses; and there are often severe rigors alternating with flushes of heat. By and by, an erysipelatous blush appears on the cheek; the surface pits on pressure, and is exquisitely painful on the slightest touch. On raising the lip, the gum over the large grinder is found to be abnormally red and tumid, evincing the same increase of disease here as in the other situations. When the natural outlet of the sinus is not obstructed, there is often, especially during recumbency, an escape of pus from the corresponding nostril, which, together with the symptoms just narrated, leaves no doubt respecting the true nature of the complaint.

The matter in this disease is rarely abundant, except in the chronic form, when it may amount to several ounces. It is generally of a thick, cream-like consistence, of a yellowish-green color, and highly fetid, apparently from its long retention. In the more violent grades of the disorder it is often intermixed with flakes of fibrin. In chronic abscess, the lining membrane usually undergoes serious structural changes, becoming thickened, flocculent, and even ulcerated, at the same time that the walls of the antrum are expanded in every direction.

Chronic abscess of the antrum is generally caused by dental irritation, or caries of the jaw-bone. In a very remarkable case, related by Professor Baum, each cavity was distended with purulent matter, from the lodgment of a tooth in its interior. The lining membrane was excessively thickened, but the osseous walls were greatly attenuated, and cracked like parchment under pressure. The patient was a woman, thirty-eight years old, and the disease, which had commenced in early life, had produced horrible deformity of the face.

The treatment of abscess of the antrum is conducted on the same principles as in abscess of the soft parts. The rule is to afford a free outlet to the pent-up fluid; if possible, before the occurrence of serious structural change. Such a step is not neglected even when there is no material obstruction in the natural orifice of the sinus, the insufficiency of this, from its elevated, and, consequently, unfavorable position, being well known. As the abscess is frequently directly dependent upon

the irritation of a decayed tooth, or as some of the teeth are apt to become involved in the disorder, the safest and most expeditious way of affording relief is to extract the affected tooth, the fang of which often projects into the sac of the abscess, and only requires removal in order to let out its contents. Should the opening thus made be inadequate, it may easily be enlarged by means of a trocar, fig. 325, a triangular perforator, or the little drill, fig. 326, constructed upon the principle of a

Fig. 325.



Perforation of the Antrum.

Fig. 326.



Pope's Antrum Drill.

trephine. Patency is carefully maintained until the mucous membrane has regained its normal functions; an occurrence which may often be greatly expedited by the use of mildly astringent injections, and suitable constitutional measures. The tooth usually selected is the middle grinder, especially if it be diseased. When the abscess points at the alveolar process, the puncture may be made there, but with a result much less promising of ultimate success. The site of a tooth that has been long extracted should never be selected for the operation, as the bone at that place is always abnormally solidified.

Alveolar abscess may be caused by external violence, by the effects of cold, or by disease of a tooth, and is characterized, at first, by the ordinary phenomena of inflammation, which, as the tendency to suppuration advances, gradually increases in violence, until the suffering becomes almost insupportable. The pain is throbbing or pulsatile, the swelling great, the tenderness exquisite. The matter, usually small in quantity, is excessively fetid, and of a thick, yellowish appearance. Its tendency to point varies. When it is far back, as in the situation of the wisdom tooth, it generally burrows between the bone and muscles, and escapes at the angle of the jaw, preceded and accompanied by great swelling, pain, and constitutional disturbance. In front, in the incisor and canine regions, it insinuates itself between the bone and periosteum of the hard palate, opening, perhaps, at length upon the surface of the soft palate. An abscess at the side of the jaw-bone, along the course of the grinders, may send its contents into the mouth, or evacuate itself through the cheek, face, chin, or upper part of the neck. An abscess connected with the upper incisors sometimes finds an outlet through the nose.

The treatment of an alveolar abscess is by timely and free incision. In the early stage of the disease, leeches, free purgation, and other antiphlogistic means are advisable, with diaphoretic anodynes to allay pain and promote sleep. Lead and opium lotions are preferable, as local applications, to poultices and warm fomentations, which have a tendency to invite the matter to the surface, and thus produce further mischief.

4. *Effusions of Blood*.—It is not improbable that considerable effusions of blood occasionally occur in the maxillary sinus, either as a consequence of external injury or of nasal hemorrhage, the blood passing into the sinus across the small aperture of communication. However this may be, it would not be likely, of itself, to be productive of any serious mischief; the most it could do would be to provoke supuration. In such an event, the same treatment would be required as in ordinary abscess of the sinus.

5. *Fistule of the Maxillary Sinus*.—The antrum of Highmore is occasionally the seat of a fistule, caused by external injury, by operations upon the jaw, or by the abnormal projection of the fang of a tooth. The passage, which is usually short and narrow, is generally situated in the alveolar process, although sometimes it is found on the cheek or on the roof of the mouth. Almost always solitary, it is sometimes multiple, and may then open both externally and internally. The diagnosis is commonly sufficiently easy, an escape of pus or of pus and mucus, and the existence of a small aperture either on the cheek or in the mouth, readily admitting a fine probe, being the most reliable phenomena of the presence of the malady.

A fistule in this situation often disappears spontaneously with the removal of the exciting cause. It is only when the opening is very large, as when it has been produced by the loss of a considerable portion of bone, that it will be likely to create trouble. In such a case, the contraction of the abnormal passage may be greatly promoted by attention to cleanliness and by the use of stimulants, aided, occasionally, by the gentle application of a heated iron. When the fistule opens upon the cheek, and refuses to yield to the ordinary measures, a cure may be hoped for by freely paring its edges, and then carefully uniting them with the twisted suture.

6. *Atrophy*.—The upper jaw is sometimes atrophied, so as to give the antrum and, of course, also the cheek, a peculiarly hollow, sunken, or depressed appearance. Such an effect may be produced by external injury or by a diseased tooth, but it may also, as in a remarkable case reported by Mr. White Cooper, arise spontaneously, or, more properly speaking, without any obvious cause. In this case, the change seems to have been owing to a gradual retrocession of the anterior and superior walls of the maxillary sinus, with a corresponding diminution of its cavity. The affection was unaccompanied by pain, but the patient, a female, aged twenty-eight, labored under constant epiphora, and was seriously disfigured in consequence of the peculiar state of the cheek. The nasal fossa was somewhat lessened in size, and the mucous membrane preternaturally dry. When Mr. Cooper first saw the case, it had already been in progress for seven years.

7. *Neuralgia*.—There is a form of neuralgia of the jaw-bones, which, so far as my information extends, I was the first to describe in 1870, although, judging from the great suffering which attends it, it has doubtless been observed by other practitioners. Its seat is in the remnants of the alveolar process of edentulous persons, or in the alveolar structure, and in the overlying gum, and is met with chiefly, if not exclusively, in elderly subjects. It is also more common in the upper than in the lower jaw. The part affected is usually very small, often not exceeding a few lines in extent. The soft tissues around do not seem to suffer, at least not in the same degree, as is so frequently the case in the more ordinary forms of neuralgia of the jaws and face. On the contrary, the morbid action is generally limited to the osseous structure. In rare instances there may possibly be some involvement of the gum, which is nearly always exceedingly hard and dense, grating more or less under the knife, and adhering with extraordinary firmness to the atrophied alveolar process beneath.

The pain is generally paroxysmal, appearing in fits and starts, very much as in ordinary neuralgia, the slightest causes being sufficient to provoke it, as talking, mastication, the contact of hot or cold fluids, deglutition, or mental excitement. Sometimes it is momentary, coming and going with the rapidity of lightning; occasionally it lasts for hours together, and cases occur, although they are rare, in which it continues, with but little mitigation, for an indefinite period. The pain varies in character. Thus, it may be sharp and darting, dull, heavy, aching, boring, or gnawing. Pressure generally relieves rather than aggravates it. Now and then, when it is uncommonly severe, there may be more or less spasm of the muscles of the face, but this is rare.

The pathology of the affection seems to be compression of the minute nerves distributed through the wasted alveolar process, dependent upon the encroachment of

osseous matter upon the walls of the canals in which they are naturally inclosed. In the normal state, the nervous current passes along without any hindrance, but in this condition of the canals in question its transmission is interrupted, and more or less pain, known as neuralgic, is the consequence. That this explanation is true does not, I think, admit of any reasonable doubt. The osseous structure, as previously stated, is always uncommonly hard, from the deposit of new substance, which imparts to it almost an ivory-like consistence.

The disease usually comes on gradually, and proceeds from bad to worse, until, in many cases, the suffering is rendered nearly intolerable. The general health, at first unaffected, is eventually materially impaired; the appetite is deranged; the countenance wears an anxious expression; the sleep is disturbed and unrefreshing; the bowels are habitually constipated; digestion is imperfectly performed; the extremities are almost constantly cold, and there is terrible depression of spirits. Loss of sleep, fatigue, exposure to cold, irregularity of diet, mental distress, and, in short, whatever has a tendency to lower the vital powers is sure to aggravate the pain and to prolong the paroxysms. Sometimes the disease would seem to be of a malarious origin, the attacks coming on periodically very much as in intermittent fever.

In all the cases under my charge, a prompt and radical cure was effected by the free excision of the offending portions of bone with a stout knife, or with the forceps delineated in fig. 327. Quinine, chalybeate tonics, arsenic, and kindred articles are frequently of service in perfecting the cure.

Fig. 327.



Forceps for Cutting Away the Alveolar Process in Neuralgia of the Jaw.

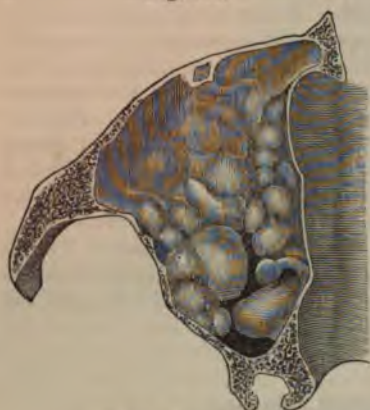
8. *Tumors.*—The upper jaw is extremely liable to various kinds of morbid growths, which generally originate in the antrum or the alveolar border of the bone, and in rare instances from the facial and zygomatic surfaces of its body or the palatine process. The relative frequency of their occurrence, as deduced by the late Professor O. Weber, from the examination of 307 recorded cases, is in the following order: Carcinoma, 133; sarcoma, 84; osteoma, 32; cystoma, 20; fibroma, 17; enchondroma, 8; gelatinoid polyps, 7; melanotic sarcoma and carcinoma, 5; and angioma, 1. He very properly remarks, however, that carcinoma figures too largely in the list, doubtless from its having been frequently confounded with medullary sarcoma, and he is disposed to believe that the latter embraces rather more than one-third, and carcinoma less than one-third, of all neoplasms of the superior maxilla.

a. *Cystic Tumors.*—Cystic tumors of the upper jaw are by no means uncommon, and they may occur either in the antrum, in the cancellous tissue of the alveolar process, or between the plates of the palatine process, as in a rare case mentioned by Dupuytren. In the first of these situations they constitute the so-called *dropsy* of the sinus, which was formerly supposed to depend upon occlusion of its natural outlet, and the consequent retention of its secretion, a mode of production, however, which is exceedingly problematical and has never been verified by post-mortem inspection. They are often developed in connection with impacted, misplaced teeth, when they are known as dentigerous cysts; but, as was originally pointed out by Giraldès, in 1853, and subsequently confirmed by the investigations of Marchant, Luschka, Virchow, and other observers, the most frequent immediate cause of these formations is cystic degeneration and enlargement of the glandular follicles which stud the mucous membrane, and are especially conspicuous on the inner wall of the chamber in the vicinity of its outlet. They may now and then be traced to simple serous cysts arising from the periosteum of the fangs of the teeth, and making their way into the antrum, as in three interesting cases recorded by Dr. Fischer, of Ulm. In one of the patients, in whom the sinus was enlarged at the expense of its facial wall, frequent puncture gave vent to a serous fluid, and each operation was followed by the disappearance of the bulging of the cheek. Examination of the bone, on the death of the man from dysentery, disclosed the antrum completely filled by a

shut sac, which contained a yellowish, watery fluid, and was connected with the second molar tooth. Its wall, one-eighth of a line in thickness, was smooth and polished on its internal surface, and was in close contact with, but not attached to, the mucous lining of the chamber.

Cysts of the antrum may be solitary or multiple, their volume, in the latter event, as represented in fig. 328, from Giraldès, ranging from that of a pea to that of a

Fig. 328.



Cysts of the Antrum.

pigeon's egg. Their contents are of a sero-albuminous character, of a whitish, pale-yellowish, or brownish color, and of a thin, watery, or glairy consistence, not unfrequently intermingled with flakes of fibrin, epithelial debris, blood corpuscles, and crystals of cholesterine. Sometimes the cyst suppurates, and thus gives rise to an abscess, attended with great pain and excessive constitutional disturbance. In cases of long standing, the cyst wall is occasionally very much thickened, and rugose on the surface, or even calcified, as in an instance of the dentigerous form of the affection referred to by Mr. Heath and Mr. Salter.

These growths are capable of acquiring a large bulk, expanding the walls of the antrum in every direction, and thus causing the most hideous deformity of the corresponding side of the face. The cheek bulges out like an immense protuberance, the nose is thrown out of shape, the eye protrudes from its socket, the nostril is com-

pletely occluded, and there is a great depression of the palate, along with excessive embarrassment in mastication, articulation, and even deglutition. Their most important diagnostic signs are, their slow, painless development, their crackling feel, or the fact that they are soft at some points and hard at others, the absence of any tendency to ulceration and enlargement of the neighboring lymphatic glands, and the excellence of the general health. When doubt exists a resort to the exploring needle may clear it up. The affection is occasionally witnessed in young subjects, but is most frequent in middle age.

The cystic tumor of the alveolar process is much more frequent than that of the antrum, its usual situation being, according to personal observations, the internal and inferior extremity of the canine fossa, where it may attain the volume of a hen's egg, or even of a small orange. It is usually single, although there may be several sacs, either closely connected together, or separated by osseous septa. The anterior wall of the tumor is composed of a thin, elastic, crackling, parchment-like shell, and is easily penetrated by a sharp instrument, the puncture giving vent to its contents, which are serous, sanguinolent, or of a glairy, mucilaginous nature. This, in fact, is the best diagnostic sign of the morbid growth. The disease is always tardy in its progress, and manifests no disposition to extend among the adjacent structures. In 1860, an old man, a patient of Dr. Piper, was brought to my clinic at the Jefferson Medical College, on account of a cystic tumor situated in the areolar tissue, immediately above the lateral incisor and cuspid teeth. It was about the volume of a lime, and distinctly fluctuated under pressure, its anterior wall crackling like parchment. Its contents were of a serous character. The tumor being opened with a stout knife, its secreting surface was freely touched with chromic acid, a tent being afterwards introduced to keep up the irritation. Healthy granulations soon sprung up, and in less than two months the cavity was completely obliterated.

The treatment of these cystic growths is easily comprehended. In the more simple forms, as in the case just mentioned, the object is readily attained by opening the sac fully, and exciting obliterative action by means of tents and stimulating injections. When the antrum is affected, the management of the case is based upon the same principles as that of abscess, evacuation of the contents of the chamber being effected at the most dependent portion of the tumor. The palate bulging, the opening is made there; or a decayed tooth is extracted, and the fluid is allowed to drain off along the resulting channel, widened, if necessary, by artificial means. Gradually the osseous cyst contracts, and, reaccumulation being prevented, it is eventually obliterated, the process being often advantageously expedited by the use of mildly

astringent injections. If the cure be very tardy, in consequence of the great bulk of the tumor, or the presence of an imbedded tooth, or multiple cysts, it will be well to cut away a portion of its outer wall and remove the offending substance, care being taken not to injure the integument of the face. When the tumor is of large size and of long standing, thorough extirpation alone will be likely to afford relief.

β. *Polyps*.—It is rare to meet with polyps of the maxillary sinus. A great variety of morbid growths, having scarcely any points of resemblance, have been described under this name, much to the detriment of sound pathology and practice. The term, however, should be restricted to those gelatinoid or vesicular growths which, being developed from the mucous membrane, are closely allied to cystic tumors, and are similar to soft polyps of the nose. Luschka met with these formations five times in sixty autopsies, and Förster, Billroth, and Virchow have delineated striking examples of the affection.

Polyps of the antrum rarely acquire large dimensions, and, therefore, seldom call for surgical interference. They have, however, been observed to attain considerable bulk, when they either protrude into the nasal cavities or expand the walls of the sinus. Under these circumstances, the symptoms and treatment do not differ from those of cystic disease.

γ. *Vascular Tumors*.—A tumor, having all the properties of an anastomotic aneurism, is occasionally developed in the maxillary sinus. It is difficult to determine whether it takes its rise in the mucous membrane of the sinus, or in its bony walls. However this may be, it appears to consist essentially in an enlargement of the branches of the internal maxillary artery, which interlace with each other in every conceivable manner, and thus form a tumor of an erectile character, similar to naevus of the face. As the affection progresses, the walls of the antrum are absorbed, and the morbid growth is thus placed immediately beneath the skin, feeling like a soft, spongy mass, and exhibiting a bluish, purple, or modena color. Its pulsation, which is synchronous with the contraction of the left ventricle, is very distinct under the finger, and may generally be seen at some distance. When the tumor is very large, it encroaches upon the eye, nose, and mouth, and is productive of great deformity.

The prominent symptoms of the disease are, its steady increase, its tendency to encroach upon the surrounding parts, its soft, spongy consistence, its pulsatile movements, and the livid discoloration of its surface, both external and internal. The attendant pain is usually slight, and the general health is seldom impaired, until after the establishment of nasal hemorrhage, which is sure to set in sooner or later, and which is often profuse and draining in its effects.

If the tumor be seen early, or, rather, if it be recognized before it has attained any considerable bulk, the proper procedure would be to expose it by a careful dissection, and effect its destruction with the actual cautery, the Vienna paste, or acid nitrate of mercury. Perhaps a portion of the growth might be constricted with the ligature, as in the operation for the radical cure of hemorrhoids. When it has attained a large size, ligation of the common carotid artery, as proposed and practised by the late Professor Granville S. Pattison, may be tried, although, it must be confessed, with but a faint prospect of success.

δ. *Fibrous Tumors*.—Pure fibrous tumors of the upper jaw are not very common, but, in connection with the lower maxilla, they constitute the larger proportion of all fibromas of the osseous system. Taking their origin in the soft layer of the periosteum or the lining membrane of the Haversian canals, they usually spring from the facial surface or the alveolar border of the bone, in the latter of which they constitute fibrous epulis. They are also developed in the antrum, either as pyriform or polypoid outgrowths, or, as more frequently happens, as lobulated tumors, which evince a great disposition to expand its walls in every direction, project into the nose, protrude the eye, cheek, and hard palate, and, finally, perforate or disintegrate the bone, which is ultimately lost in the new product.

The fibrous tumor of the upper maxilla almost always contains small masses of hyaline cartilage and spicules of bone, the latter element often being so predominant as to entitle it to be called osteoid fibroma. The osseous proliferation of the periosteum, indeed, may invade the fibrous tissue to such an extent as to convert the growth into an osteoma, and many exostoses, doubtless, arise in this way. On the other hand, but very seldom, numerous cartilaginous nodules are interspersed through the mass, giving rise to lobulated tumors, which are appropriately termed enchondromatous fibromas. In addition to these transformations, cysts or cavities, con-

taining various kinds of fluids, are sometimes interspersed through its substance, and also serve to give the growth a mixed character. In rare cases, the tumor is composed of pure, dense, compact, interlacing fibrous tissue, which creaks under the knife, and has a very feeble circulation. Its volume, although generally small, sometimes equals that of the fist; it manifests no malignant tendency, and rarely returns after extirpation. Its attachment is usually by a broad, ill-defined base, but now and then it is by a narrow pedicle, similar to what is observed in fibrous polyp of the nose. Middle-aged persons are its most frequent subjects.

Fibrous tumors of the superior maxilla are distinguished from medullary, sarcomatous, and carcinomatous formations, first, by the tardiness of their growth; secondly, by their globular, ovoidal, or pyramidal shape; thirdly, by their circumscribed character, or indisposition to ramify through the surrounding parts; fourthly, by their firm, unyielding consistence; fifthly, by their painlessness; and, lastly, by the absence of contamination of the neighboring lymphatic glands. There is, moreover, little tendency in such tumors to ulceration; the mucous membrane of the mouth retains its florid appearance; and there is much less sanguinolent discharge from the nose than in carcinoma. The general health is not deteriorated, and the countenance is free from that sallow and dejected expression which forms so striking and characteristic a feature in malignant disease.

A fibroma of the antrum, or on the exterior of the bone, may occasionally be approached by the mouth, the outer wall of the cavity being opened just above the roots of the teeth. When the wall is very thin and soft, the operation may be performed with the knife; when the reverse is the case, it may be necessary, in addition, to use a gouge and mallet. The cheek is, of course, detached from the bone for some distance as a preliminary measure. I have, on several occasions, enucleated fibrous tumors from the antrum in this way with very satisfactory results, and the plan should always, if possible, be adopted in preference to any other, as it is unattended with disfigurement of the face. It will also be well to remove the portion of the bone to which the growth is attached. When the morbid growth is uncommonly large, it is generally necessary to attack it through the cheek, as in the extirpation of malignant tumors. Little hemorrhage usually accompanies such operations, provided the tumor is not opened in the dissection.

A fibroma, or osteoid fibroma, occasionally springs from the alveolar border of the upper jaw, in connection with the periosteum, or with the lining membrane of the socket of one of the teeth, when it is termed *fibrous epulis*. Arising generally, according to my observations, in one of the molar alveoli, epulis originally consists of a small, fleshy-looking tubercle, situated at the side of one of the teeth, which, in time, becomes displaced, loose, and ultimately drops out. During its progress, which is slow and painless, it advances into and carries the gum before it, and forms a mass of a dense, firm consistence, of a florid color, of an irregularly rounded shape, somewhat like a mushroom, its point of attachment being usually much smaller than its free extremity. The surface is smooth and regular, although it may be lobulated, and it is liable to ulceration, when the growth becomes painful, not unfrequently bleeds more or less copiously, and is the seat of a constant, offensive discharge.

Fibrous epulis is composed of dense, white, shining, interlacing tissue, the fibres of which are interspersed with delicate osseous spicules, which pass into its interior from its attachment to the alveolus. The glands of the gum are sometimes much enlarged. Its volume rarely exceeds that of a walnut, and, although it almost always grows downwards towards the buccal side of the jaw, it may perforate the alveoli and protrude into the antrum. The tardiness of its development, its firm, elastic consistence, its comparatively small bulk, and the freedom from contamination of the neighboring lymphatic glands, are the signs by which it is distinguished from sarcomatous and carcinomatous epulis.

Fibrous epulis being a benign affection and showing little disposition to local return after extirpation, its management may be restricted to thorough removal of the socket from which it springs; but, if several cavities be involved, the excision of the alveolar border of the bone, and cauterization of the exposed surface with the hot iron may be necessary. If the substance of the jaw be deeply involved, the only way to deal with the malady is to remove a portion embracing its entire thickness, and reaching for some distance beyond the limits of the morbid mass. Violent hemorrhage sometimes accompanies such operations, as in a fatal case reported by

Billroth, in which the blood, coagulated by Monsel's solution, gained access into the windpipe, and necessitated the operation of tracheotomy.

4. *Cartilaginous Tumors*.—Enchondroma of the upper jaw must be ranked among the rarest of these neoplasms. I have myself never met with an example, but cases have been recorded by Morgan, Beck, Partridge, O'Shaughnessy, Heath, Buck, and others, in which it was developed between the periosteum and the bone, its most common sites being the facial surface and the nasal process. With the exception of a case, referred to by Rindfleisch, in which the growth was the seat of numerous clefts, thus imparting to it a papillary or cauliflower-like appearance, I am not aware of an instance of pure cartilaginous tumor of the antrum. Dolbeau and Trélat have described an osteoid chondroma of the sinus; Giraudeau met with a myxomatous enchondroma; and Mr. Stanley has delineated a remarkable example of sarco-enchondroma, in a lad sixteen years of age, which involved both cavities, as well as the left orbit, extended into the skull and left nasal cavity, and protruded into the pharynx. The maxillary and pharyngeal portions of the tumor were of the nature of fibrous sarcoma.

Enchondroma of the superior maxilla is capable of attaining enormous dimensions, as in a case of successful operation by Mr. O'Shaughnessy, in which the tumor was nearly as large as the patient's head, and weighed four pounds. Such a growth is seldom distinguished during life from some of the other formations incident to the jaw. The diagnosis is based mainly upon the firm consistence of the tumor, its tardy and painless development, its appearance at an early age, and its indisposition to ulceration. The general health is not materially impaired as long as the patient retains the power of deglutition. These features, however, are not characteristic of the cartilaginous tumor, as they are also common to fibrous and osseous growths.

5. *Osseous Tumors*.—The superior maxilla is liable to exostosis. The morbid growth, varying infinitely in regard to its size and form, is most common in old and middle-aged subjects; it may appear upon any part of the bone, and, gradually augmenting in volume, may at length involve its entire extent. It is strictly a local affection, the result generally of external violence, or of a syphilitic taint of the system; and rarely, if ever, degenerates into malignant disease.

An exostosis is easily recognized. Its chief peculiarities are, its excessive hardness, its slow growth, its freedom from pain, the absence of disease in the surrounding structures, and the unimpaired state of the general health. There is no discharge of blood, mucus, or pus, no tendency to ulceration, no alteration, at least not for a long time, in the skin of the face, or in the lining membrane of the mouth: the principal inconvenience is from the size of the morbid growth, which is occasionally enormous, and from its consequent interference with the functions of the adjacent parts. When doubt exists, a small exploring needle, introduced at various points of the tumor, will at once decide the question.

Instead of an outgrowth, the osseous tumor may occur in the form of general or partial *hypertrophy* of the bone. An interesting case of hyperostosis of the entire superior maxilla, along with its ascending process, in a girl, fifteen years of age, has been reported by Mr. Stanley. The affection included every part of the bone, and caused complete obliteration of the antrum. Other examples of diffused hypertrophy, or "osseous leontiasis," in which, in addition to the superior maxilla, other bones of the face were involved, thus giving rise to great deformity, have been recorded by Howship, Sir Astley Cooper, Gruber, and Bickersteth. Partial hyperostosis of the alveolar border of the bone, depending upon the irritation of an inverted tooth, is occasionally met with. An instance of the kind, the only one I have ever seen, fell under my observation in 1843, in a young lady, aged twenty-one. The enlargement, which had been first noticed two years and a half previously, and which was about the volume of a large hickory-nut, occupied the alveolar process of the left jaw, and was of a hard, firm consistence, free from pain and soreness, unaccompanied by disease of the gum, or derangement of the general health, and formed at the expense mainly of the outer plate of the bone. Upon sawing into the tumor, it was found to be occupied by a cuspid tooth, a little smaller than natural, but well grown, with the crown reversed, or directed upwards towards the antrum of Highmore. The parts soon healed, with hardly any defect, save what resulted from the extraction of the canine tooth, which was deemed necessary as a preliminary step.

Little, if, indeed, anything, is to be accomplished in this disease by medical treatment. When the tumor is young and small, the external and internal use of iodine may be serviceable in diminishing, and even in eradicating it. A mild mercurial course, conjoined with the internal exhibition of iodide of potassium, is indicated when it is dependent upon a syphilitic taint of the system. A growth of this kind has been known to drop off spontaneously. But such an event is not to be looked for, nor, as before stated, is much to be expected from therapeutic agents. In general, nothing short of extirpation will answer, and this, fortunately, is usually readily accomplished by the ordinary means.

7. *Sarcomatous Tumors*.—By far the most frequent of all tumors of the upper jaw, whether developed from the soft layer of the periosteum or from the medulla, are the sarcomatous, which may spring from the body of the bone or from its alveolar border, constituting in the latter situation sarcomatous epulis.

Periosteal sarcoma of the body of the superior maxilla is principally observed in young adults, in connection with its external surface and the orbital and facial boundaries of the antrum. Usually composed of fasciculated, spindle-celled tissue, intercalated with a few giant cells and radiating spicules of bone, the latter of which are sometimes so numerous as to entitle it to the name of osteoid sarcoma, it gives rise to a dense, firm, smooth, ovoidal or globular swelling, which is now and then traceable to injury, is of slow and painless growth, and presents on section the gross appearances of osteoid fibroma, from which it is almost indistinguishable without the aid of the microscope, and between which and exostosis it appears to hold an intermediate position. The softer forms of the affection, consisting of small round or spindle cells, however, increase rapidly and attain large dimensions, thereby imitating carcinoma in their general features. When seated between the periosteum and the facial surface of the bone, the tumor, covered by the distended, but otherwise unchanged, periosteum, mucous membrane, and integument, generally proceeds outwardly, elevating the ala of the nose, the lip, and cheek, although it may produce absorption of the bone and penetrate the antrum. When, on the other hand, it originates in the maxillary sinus, its disposition is to fill that cavity and protrude into the nose, mouth, pharynx, and even the skull. In this situation periosteal sarcoma occasionally presents a papillary or cauliflower-like appearance, rendering it liable to be mistaken for epithelioma, as in a case described and delineated by Mr. Christopher Heath. The soft, friable, morbid growth occupied the left antrum of a man, seventy-six years of age, projected into the nose, pushed out all of the teeth of the corresponding jaw, and was attended with a constant purulent discharge, but no pain.

Central, myelogenic, or myeloid sarcoma, which includes a variety of epulis, designated by Nélaton the encysted intraosseous, is, according to my observations, less common in the upper than in the lower jaw. Rarely witnessed after the fortieth year, it is most frequent between the ages of fifteen and twenty-five, and often appears soon after the second dentition. Arising, as a rule, in the spongy substance of the internal and inferior extremity of the canine fossa and the medulla between the anterior molar alveoli, its structure essentially consists of very numerous giant cells, contained in an apparent stroma of spindle-celled tissue, as depicted in fig. 57, Vol. I., although a small round-celled or glious basis is not infrequent. At its commencement, the plates of the bone, by the addition of new osseous matter from the periosteum, form a more or less perfect capsule for it, but this, in part, finally disappears through disintegration and absorption, thereby permitting the mass to make its way into the antrum, the nose, or the mouth, through the alveolar or palatine process. In rare instances, the soft tissues of the cheek and lip are invaded and perforated, when the tumor assumes a malignant aspect, and bears a close resemblance to medullary carcinoma.

The myeloid tumor of the jaw is distinguished from fibroma and periosteal sarcoma by the early age at which it appears, its more rapid growth, its elastic, parchment-like feel, its lobulated outline, and a sense of fluctuation when it has in great measure undergone the cystic degeneration. In some cases it is highly vascular, the vessels being so much enlarged as to impart to it a distinct pulsation, rendering it liable to be mistaken for anastomotic aneurism. On section, the surfaces are succulent, shining, soft, and easily broken down, and present a modena, brownish-red, or greenish tint. The tissue, rarely interspersed with osseous spicules, usually

presents under the microscope a predominance of giant cells, although the soft, gelatinous forms of the affection consist mainly of spindle cells.

The treatment of the sarcomatous tumor of the body of the upper jaw does not differ from that of fibrous growths. When small, the portion of the bone from which it arises should be freely excised, whereas, in the case of the myeloid tumor, the mere cutting away of the anterior wall of its capsule, and freely scraping the cavity in which it lies, generally suffice to prevent repullulation. When, on the other hand, the mass has acquired a large bulk, and involves the greater portion of the bone, the entire jaw will have to be sacrificed.

Sarcomatous *epulis* may arise from the alveolo-dental periosteum of a socket or from the medulla cells of the enlarged Haversian canals. In the former case, it is usually composed of closely aggregated spindle cells, intermixed with bundles of fibrous tissue, spicules of bone, and a few giant cells, whence it may not improperly be termed osteoid fibro-sarcoma; while, when it originates in the medulla, it may more appropriately be called myeloid or myeloplasic sarcoma of the alveolar border of the bone, since giant cells predominate in its structure. The general features of sarcomatous *epulis* do not differ from those of the purely fibrous variety, to which, indeed, osteoid fibro-sarcoma is closely allied, although there is a form of the latter which, being composed almost entirely of small round or spindle cells, is quite soft and vascular, and, therefore, pursues a more rapid course, and is more disposed to local return. Myeloid *epulis* is not so firm and resistant as the periosteal growth, and it usually attains a larger size. The distinction, however, between fibrous and sarcomatous *epulides* is almost impossible before their extirpation.

In all cases of sarcoma of the alveolar border of the jaw-bones that have fallen under my observation, and their number has been considerable, the repullulating disposition has been most remarkable, although I have never known it to give rise to lymphatic involvement or similar deposits in the internal organs. Hence, the only remedy for the affection is early and thorough excision, not of the tumor, or of the parts from which it grows, but of the portion of the bone in which it has its origin. Although periosteal *epulis* is sometimes developed in a socket, and may be removed by extracting the tooth from the membrane of the root of which it springs, yet this simple operation, combined with the superficial shaving off of the growth, as advised by some surgeons, is worse than useless. The only way is to deal it at once an effectual blow by sawing out a piece of the jaw, embracing its entire thickness, and reaching some distance beyond the limits of the morbid mass. I have never known a case in which any other procedure did the least good. In treating *epulis*, we should not lose sight of the fact that it is an affection, not so much of the gums as of the jaw-bone; and, therefore, anything short of the removal of this, at the site of the disease, is an absurdity.

6. *Carcinomatous Tumors*.—By far the most common, as well as the most formidable, of the carcinomatous affections of the upper jaw are encephaloid and epithelioma. Scirrhus is extremely infrequent. I have never seen an instance of it, but, if it should ever occur here, it would be most likely to show itself in advanced life, in a hard, firm, solid tumor, slow in its progress, and characterized by sharp, lancinating pain. It would not attain as great a bulk as the softer forms of carcinoma, nor would it be so liable to fungate and bleed. Of primary colloid and melanosis of the upper jaw, we are almost entirely ignorant.

There are no signs by which encephaloid can be discriminated from epithelioma. Both are soft and medullary; grow rapidly, and soon acquire a large bulk; usually occur after the twentieth year; and have the same sources of origin. Possessing so many features, clinical and anatomical, in common, any distinction that may be attempted to be drawn is exceedingly difficult, if not impracticable. Hence, it will be understood that both forms of carcinoma are included in the following remarks.

Carcinoma occurs here, as elsewhere, in both sexes, in all classes of individuals, and at all periods of life. I have witnessed it in children under five years, in young adults, at middle life, in old age, and in decrepitude. It is, however, undoubtedly most common between the twentieth and fortieth years. It is not known what influence, if any, occupation, temperament, climate, and other circumstances exert upon the development of this disease. In all the instances of it, except one, that have fallen under my observation, it arose without any obvious cause.

The disease usually begins in the cavity of the antrum, in connection with the glands of the mucous membrane. Occasionally it takes its rise in the cancellated

structure of the bone, or in the periosteum; or it may originate in the mucous glands of the gum and palate, and involve the bone secondarily. In the first case, it generally progresses until it fills up the whole sinus, after which it encroaches upon the bony parietes of the cavity, pushing them out in every direction, and thereby pressing them against the surrounding structures. As the external wall is extremely thin, in fact a mere shell, in the natural state, the morbid growth commonly advances more rapidly in this direction than in any other, forming thus, frequently at an early stage, quite a large tumor on the cheek. By and by, as it proceeds in its development, it extends towards the nostril, partially, and sometimes completely, occluding the corresponding cavity; upwards towards the floor of the orbit, compressing and ultimately protruding the ball of the eye, or even penetrating the skull through the ethmoid bone; downwards towards the palate, displacing the tongue, and diminishing the mouth; and backwards towards the fauces, impeding mastication, deglutition, speech, and respiration. At this stage of the disease the countenance is most hideously disfigured, and the patient is an object well calculated to excite commiseration. The appearances here described are well seen in figs. 329 and 330.

Fig. 329.



Carcinoma of the Antrum, Encroaching upon the Face.

Fig. 330.



Carcinoma of the Antrum, Encroaching upon the Mouth.

The overlying integument and mucous membrane are generally sound in the earlier stages of the complaint; but after a certain period, varying from several months to a year, they assume a livid and congested appearance, and at length yield to ulcerative action. The consequence is a fungating and rapidly spreading sore, the seat of a thin, sanious, muco-purulent, or sanguinolent discharge, very abundant, excessively fetid, and highly irritating. Pure blood often proceeds from it; sometimes very small in quantity, at other times so copious as rapidly to undermine the strength, and bring on hectic fever, with exhausting night-sweats.

In the later stages of the disease, when ulceration has set in, the lymphatic glands of the temple, behind the ear, and under the jaw, occasionally become enlarged and contaminated, and finally give way from over-distention. This immunity of the glands is peculiar to carcinomatous diseases of the upper jaw, doubtless for the reason that the antrum is poorly supplied with lymphatic vessels. The countenance assumes a peculiar cadaverous expression; the patient rapidly loses flesh and strength; colliquative diarrhoea supervenes; the pain is excessive; and death finally occurs from exhaustion. The progress of the malady is variable; sometimes very rapid, at other times quite tardy. I have seen death produced by it in less than six months from its commencement; and, on the other hand, I have met with cases in which the fatal event did not take place under four years. The affection, according

to my experience, is usually more rapid here, as elsewhere, in children and youths than in the middle-aged and old.

The tumor, after removal, exhibits, under the microscope, round cells, or squamous and cylindriform epithelium, contained in a soft, alveolar basis-structure. That portion which occupies the antrum is commonly very soft and pulpy, resembling, at least faintly, both in color and consistence, a section of the brain. The osseous structure is broken down and disorganized, quite vascular, and so porous as to be easily cut. In some places, and in some specimens, it is entirely, or nearly entirely, absorbed; while in others it is replaced by fibro-cartilage, or cartilage, intermixed with spicules and scales, remnants of the original tissues. In the majority of cases, the morbid growth is remarkably vascular, as it is pervaded in every direction by large vessels, the walls of which are exceedingly brittle, and, therefore, liable to yield under the slightest impulse. It is owing to this circumstance that these tumors frequently attain such an enormous bulk, and that, when ulceration sets in, they are so liable to fungate and bleed.

The diagnosis of carcinoma of the superior jaw, however commencing, is usually not difficult. The rapid growth of the tumor, its steady encroachment upon the adjacent parts, its soft and elastic feel, the livid aspect of its buccal portion, and its sharp, darting pains, readily distinguish it from all other formations. In the later stages of the affection, the fungous character of the ulcer, and the sanious, sanguinolent, or bloody discharges, together with the sallow and cadaverous state of the countenance, and the enlargement of the neighboring lymphatic glands, leave no doubt about its nature. The exploring needle will at once inform us as to the consistence of the morbid product, and the nature of its contents. If the mass have undergone the cystic degeneration, an escape of serum, or muco-sanguineous fluid, will afford the necessary intelligence, and enable us to shape our course accordingly; while, if carcinomatous matter be present, the smallest particle will, if subjected to the microscope, reveal the characteristic structure.

Carcinoma of the jaw seldom coexists with malignant disease in other parts of the body. The affection, in fact, in the great majority of instances, is more local in its character than when it invades other tissues or organs. It is, doubtless, owing to this circumstance that excision of the disease, especially in its earlier stages, when it is, as it were, incapsulated in the bone, is occasionally successful, although in general the prognosis is most unfavorable.

Carcinoma of the alveolar border of the superior maxilla, in the form of epithelioma, or, occasionally, of melanosis, usually begins in the glands of the gum, from which it gradually extends to the bone, and constitutes *carcinomatous epulis*. Arising generally in the vicinity of the molar teeth, it consists of a florid or purplish mass, with a firm, elastic base, and a coarsely granular, papillary, cleft, or cauliflower-like surface, which soon ulcerates, manifests a great tendency to bleed, and is the seat of severe pain, with a fetid, sanious discharge. The affection is peculiar to advanced life, although it has been observed by Soulé and Wützer, respectively, at the third and eleventh year. The cervical lymphatic glands almost invariably enlarge, and the constitution evinces signs of contamination, early in the disease, the duration of life from the time of its first appearance often not exceeding eight months. These features, along with the possibility of expressing a juice and a soft, cheesy substance, are sufficient to distinguish carcinomatous from fibrous and sarcomatous epulides. The prognosis of this affection, if removed in its early stages, is favorable. When, however, it has attained considerable volume, excision of the entire bone is indicated. Under these circumstances, partial extirpation will be sure to be followed by repullulation, not only at the cicatrice but also in the neighboring glands.

EXCISION OF THE UPPER JAW.

Excision of the upper jaw is required chiefly in malignant disease, and under such circumstances it may be necessary to remove, at the same time, portions of the malar, turbinated, ethmoid, and sphenoid bones, which are often involved in the morbid action. A part of the upper jaw was removed by Acoluthus, as early as 1693; but the honor of first extirpating the whole of it is due to the late Dr. Jameson, of Baltimore, who achieved the enterprise successfully in 1820.

The patient, during the operation, should always be placed recumbent, especially if the tumor is of considerable bulk, and a good deal of time is required to effect its

removal. The head and shoulders should be well elevated, and the face inclined towards the opposite side. Very few persons, whatever may be their courage or fortitude, can bear the shock and fatigue of an undertaking of such magnitude in the sitting posture. This precaution is the more necessary if chloroform be given, as I always do in such cases. I am aware that objections have been urged against the administration of this remedy in operations on the mouth, but without, I believe, any just reason. Be this as it may, I have employed this agent, ever since its introduction into practice, in all the amputations, both of the upper and lower jaw, that have fallen under my observation, and I have certainly, thus far, had no cause to regret it. The mouth can always be easily cleared of blood, even if the patient is unconscious, with the finger, or a sponge-mop.

I have never found it necessary, in any of my operations on the upper jaw, to secure the carotid artery, as a means of preventing hemorrhage. Indeed, it is surprising that such a procedure should ever have been recommended, much less practised, by any one. My experience is that there are no structures in the body, of the same extent, in their natural and diseased condition, the removal of which is attended with so little hemorrhage. No skilful surgeon now even employs compression of the carotid artery in these operations, and, as to tying that vessel as a means of security against loss of blood, nothing, it seems to me, could be more absurd and unnecessary. The chief danger from hemorrhage is in the subcutaneous arteries, especially the facial and its branches, and these are always readily controlled by the ligature. The deep-seated arteries, involved in tumors of the upper jaw, seldom bleed much, if care be taken to keep beyond the limits of the diseased tissues. If this precaution be neglected, the hemorrhage may be copious, if not exhausting. The oozing which takes place from the osseous surface, after the exsection is completed, generally speedily ceases of its own accord from the contact merely of the air; when it does not, it is usually easily arrested by compresses wet with a saturated solution of subsulphate of iron. The actual cautery can only be required when the vessel is inaccessible to the ligature, or when a portion of the disease has unfortunately been left behind.

In operations upon the upper jaw, unattended with loss of the alveolar and palatine processes, the escape of blood into the throat may generally be effectually prevented by previous plugging of the posterior nares.

The direction, extent, and number of the incisions through the soft parts must necessarily vary with the situation and volume of the tumor. In all these respects, much must be left, in every case, to the judgment and experience of the operator. When the morbid growth is comparatively limited, and seated upon the anterior, or antero-lateral, aspect of the jaw, we shall generally be able to dispense with external incisions altogether, as the object may readily be accomplished simply by dissecting off the lip from its attachments to the bone, and holding it out of the way with a finger or blunt hook. The surface of the tumor having thus been thoroughly denuded, the bone is attacked with the pliers, and severed fairly beyond the line of the disease. By this procedure, which is admirably adapted to the more simple forms of morbid growths, the operation is divested of much of its severity, and not followed by any deformity of the features, save what results from the caving in of the integument.

When the tumor involves the body of the jaw, and is of considerable bulk, the plan which I usually adopt, is to make one long, curvilinear incision, extending across the most prominent part of the tumor, from the commissure of the lips towards the zygomatic process of the malar bone, terminating within a few lines, half an inch, or an inch, of the external angle of the eye, according to the exigencies of the case. In this manner are formed two flaps, the upper of which is convex, and the lower concave, which are then carefully dissected up by bold and rapid strokes of the knife, and held out of the way by trustworthy assistants, who, at the same time, take care to compress the bleeding vessels. The space which this procedure affords is, in general, quite sufficient for the easy removal of the entire tumor, however large or extensive its connections. In my own cases, it has always answered the purpose most thoroughly. Should it, however, be inadequate, it can readily be increased to the requisite extent by carrying the knife horizontally along the inferior border of the orbit, as far over as the nose, as exhibited in fig. 331, from a patient affected with encephaloid disease of the antrum, whom I attended with Professor Pancoast. In making the first of these incisions, the facial artery is neces-

sarily divided, and, in the second, the superior maxillary nerve, together with many of the branches of the portio dura of the seventh pair. In consequence of the injury thus sustained, the parts supplied by these nerves remain a long time paralyzed, although ultimately the face regains, in great degree, its accustomed power and expression.

When the tumor, or enlargement, occupies the anterior and upper portion of the jaw, the external incision may extend vertically upwards by the side of the nose, from the free border of the lip to a level with the orbit of the eye. This will enable the operator to detach the wing of the nose, and to remove, if necessary, the ascending process of the jaw-bone, the lachrymal bone, the inferior turbinated bone, and even the vomer, as I have been compelled to do in several instances.

When the antrum is mainly implicated in the disease, two incisions, representing the form of an inverted T, are necessary, the vertical limb corresponding with the ascending process of the maxillary bone, and the horizontal one with the inferior border of the orbit of the eye. When the tumor is not very large, access may readily be obtained by making a vertical incision through the upper lip, and dissecting away the ala of the nose, as practised by O'Farrall, Syme, and other surgeons; a method which I have myself repeatedly followed with great advantage as it respects the resulting scar.

Whatever may be the form and direction of the incisions, care should be taken that they are sufficiently extensive to afford ready access to the diseased mass. Nothing can be more embarrassing, or display greater defect of judgment in the operator, than a want of room in a case of this kind.

The necessary incisions having been made, and the flaps dissected up, the next step is to remove the tumor. As a preliminary measure, two teeth, one in front and the other behind, must be extracted, to make room for the play of the saw and other instruments. As a general rule, this part of the operation should be performed as soon as the patient is fairly under the influence of chloroform, and, consequently, prior to the division of the soft structures. If done after that, it is liable to occasion delay and annoyance.

The separation of the jaw is generally the work of a few minutes. The limits of the disease being usually well defined, care must be taken to keep on the outside of them, for the twofold purpose of avoiding hemorrhage and removing the whole of the morbid structures. The best contrivance for executing this part of the operation is a pair of pliers. The surgeon should supply himself with at least three of such instruments, of different shapes and sizes, figs. 332, 333, 334, as one is rarely sufficient for the purpose. He should also have several chisels, small saws, a lenticular, and a stout scalpel, the handle of which should terminate in a steel point, that it may be used as a scraper and a cutter, as may be found most expedient.

When it is designed to remove the entire jaw, the saw or pliers should be successively carried through the alveolar process in front, and the horizontal plate behind, close to the middle line, as far back as the corresponding portion of the palate bone, the mucous membrane of the roof of the mouth having been previously divided with the scalpel, to prevent it from being bruised and lacerated. Next, the instrument is to be applied to the malar bone, at or near its junction with the maxillary, and, finally, to the nasal process, which is generally divided on a level with the lower margin of the orbit. The orbital plate of the jaw-bone is commonly left intact, at least in part, as it rarely participates in the morbid action. Should it do so, however, it should be cautiously removed with the chisel and knife, lest the eye and its appendages be injured. All that now remains to be done is to

Fig. 331.



Lines indicating the Course of the Knife in Excision of the Upper Jaw.

Fig. 332.



Fig. 333.



Fig. 334.



Different Forms of Bone-forceps.

sever the tumor at its junction with the pterygoid process and palate bone; and here, again, the chisel and knife will come into excellent play. Occasionally the bones, after having been pretty well divided, may be forcibly wrenched from their bed by grasping them firmly with the lion forceps of Fergusson, represented in fig. 335. The main tumor having been removed, the parts are carefully sponged, and any remnants of diseased substance that may appear are cleared away with the lenticular, gouge, and other suitable instruments.

Fig. 335.



Clawed Forceps.

It is seldom that more than three or four ligatures will be needed. To stop the oozing of blood from the deep portion of the wound, and counteract the sinking in of the cheek, the bony gap should be well stuffed with lint, wet with a saturated solution of subsulphate of iron. The external wound is closed with the twisted suture, and supported by a compress, secured by a roller, passed around the head and chin in the form of the figure 8.

When the tumor is attached to the base of the skull, or skull and posterior nares, as it may be when it is of a fibrous or sarcomatous nature, the operation is one of great difficulty, and in more than one instance the patient has rapidly sunk from the effects of shock and hemorrhage.

Excision of the entire upper jaw is not dangerous. I have performed it upwards of a dozen times without a single loss. Of 17 cases, collected by Hutchinson, from the practice of the London Hospitals, 14 were successful; and of 10 operations performed by Esmarch the result was equally flattering in 8. The tables of Heyfelder show that death ensued 26 times in 112 complete excisions of one jaw, and 36 times in 187 partial excisions. Of 9 excisions of both bones, 4 either died or the disease recurred at an early date.

Excision of both superior maxillary bones was originally performed, in 1844, by Dr. J. F. Heyfelder, on account of carcinoma. The operation has since been repeated by Maisonneuve, Deitz, Jüngken, Rogers, Langenbeck, and other surgeons. Dieffenbach, in 1848, removed the greater part of both upper jaw-bones, along with the palate and malar bones. Should such an operation be necessary, access to the diseased structures could readily be obtained by two curvilinear incisions, extending from the commissures of the lip to within a short distance of the outer angle of the eyes.

The after-treatment is strictly antiphlogistic; and, as the great danger to be apprehended is erysipelas, every means should be used to avert its occurrence. The pins are removed at the end of the third or fourth day, when the edges of the incision will generally be found to be perfectly united. I have repeatedly seen wounds, eight and nine inches in length, close by the first intention after these operations. The patient soon becomes accustomed to his loss; and the function of deglutition, at first so difficult and annoying, is gradually performed with its original facility. Even the faculty of mastication is regained much more rapidly than one, unacquainted with the compensating powers of nature, might be led to suppose. The deformity of the face is often comparatively trifling; and the defect in the mouth may usually be remedied, in the more favorable cases, by artificial means. It is surprising how much, even in a short time, the cavern contracts, and how all the surrounding and associated parts accommodate themselves to their new relations.

When the tumor is carcinomatous, it will be sure to return, sooner or later, in almost every instance, however thoroughly it may have been extirpated. In the non-malignant formations, on the contrary, there is no reason to apprehend a relapse, any more than in the same class of affections in other parts of the body.

TUMORS OF THE SPHENO-MAXILLARY FOSSA.

As a kind of an appendix to morbid growths of the upper jaw, I may here briefly describe what are called tumors of the sphenomaxillary fossa, a subject discussed with much care by Professor Langenbeck, of Berlin.

These tumors may be of various kinds, as the fibrous, vascular, osseous, sarcomatous, and carcinomatous, all of which are capable of acquiring a considerable bulk, and of penetrating, during their development, the base of the skull, and thus destroying life. Their diagnosis is, therefore, of the greatest importance, especially as they may be easily and safely removed in the earlier stages of their existence.

The precise point of origin of these morbid growths is variable; in general, they spring from the pterygoid process of the sphenoid bone, from the body of this bone, or from the superior maxilla. However this may be, they always advance, at first, in the direction of the least resistance, which is above and below the malar bone, where they, consequently, soon slightly elevate the cheek and temple. In time, they cover the whole exterior of the upper jaw, distend the temporal fossa, and penetrate the orbit through the sphenomaxillary fissure, pushing the ball of the eye upwards and somewhat forwards. They also gradually force their way through the sphenopalatine foramen into the posterior nares, driving the mucous membrane before them, and thus occasioning more or less obstruction of the nose. The facial portion of the morbid growth usually presents a remarkably constricted appearance, owing to the situation of the malar bone. The resistance of the pterygoid fascia effectually prevents the tumor from descending into the cervical region. Severe pain is generally experienced, especially when the mass is of large size, and, in that event, there is also great difficulty in opening the mouth.

The fibrous tumor of the sphenomaxillary fossa is characterized by its slow development and great firmness; the vascular, by its softness, by its deceptive sense of fluctuation, and by its marked diminution under pressure. The osseous tumor, besides being rare, grows very tardily, and seldom attains a large bulk. Its great feature is its excessive hardness. The carcinomatous tumor is distinguished here, as everywhere else, by the rapidity of its formation, by its unequal consistence, and by the great volume which it is capable of attaining. Perforation of the cranium cannot be diagnosticated with certainty, inasmuch as it may occur without inducing any symptoms. Youth and middle age are the periods of life most liable to these different morbid growths.

The extirpation of these tumors can only be effectually accomplished by the removal of the greater portion of the malar bone with the saw or pliers. The incisions through the integument should be shaped in such a manner as that, while they afford free access to the morbid mass, they may not lead to any undue deformity. The temporal muscle must, of course, be divided, either partially or completely. The attachment of the growth is usually by a comparatively small pedicle. No serious embarrassment need be anticipated from hemorrhage, especially if the tumor be kept free from the knife.

In the case of an old woman, under the charge of Dr. P. Heron Watson, of Edinburgh, in 1868, in which a large fibrous growth occupied the pterygo-buccal region, extirpation was successfully effected, with hardly any loss of blood, by an incision carried from the free margin of the lip to the mental prominence, and thence along the base of the bone to the lobe of the ear, after which the lower jaw was divided opposite the bicuspid tooth, and turned out nearly at a right angle with the zygoma, so as to expose the pterygoid region and the greater portion of the tumor, which was then carefully liberated from its attachments to the muscles of the jaw and pharynx, the carotid arteries, internal jugular vein, and the deep cervical nerves. After the large wound was sponged out, and the bleeding checked, the jaw was restored to its natural position, the severed ends being connected together by silver wire. Rapid recovery ensued.

SECT. II.—AFFECTIONS OF THE INFERIOR MAXILLARY BONE.

The lower jaw-bone is subject to various affections, of which the principal are abscess, caries, necrosis, and different kinds of tumors.

1. *Chronic Abscess*.—The lower jaw, like other bones, is liable to the formation of a circumscribed abscess, small in size, slow in its progress, lined by a distinct membrane, and filled with thick matter, the affected tissue being much increased in bulk and density. The disease, observed chiefly in young subjects, may be caused by external injury, by cold, by the action of phosphorus, or by the irritation of decayed teeth. The symptoms are generally obscure, the most prominent being a gradual enlargement of a particular portion of the bone, with a sense of excessive hardness, more or less tenderness on pressure, and fits of acute pain, recurring at variable intervals, with difficulty of separating the jaw and of masticating, and gradual failure of the health. The treatment consists in exposing the abscess with

the trephine and evacuating its contents. If the textural lesions are very great, complete excision of the affected parts may be necessary.

Fig. 336 exhibits the ramus of the left lower jaw, which, along with the coronoid process, was the seat of a central abscess. Under the supposition that it was a solid growth—for there were no symptoms pointing to supuration—I removed it by disarticulation and resection, when it was found to contain nearly three ounces of thick matter. The inner wall of the bone above the attachment of the internal pterygoid muscle was porous and covered by thickened periosteum, while the outer plate was normal. The interior of the abscess was lined by a membrane. The patient, nineteen years of age, had received a blow at the seat of the disease twelve months previously.

2. *Caries*.—Caries of this bone does not require any particular notice, as it is neither frequent in its occurrence, nor peculiar in its character. Various causes may induce it, as external injury, the irritation of a decayed tooth, mercurialization, or a scorbutic, strumous, or syphilitic taint of the system. Whenever it takes place, the nature of the exciting cause should, if possible, be traced out, and the case treated accordingly.

3. *Necrosis*.—Necrosis is also uncommon, being witnessed principally as a result of profuse pyaliam, especially in young and weakly persons, of a strumous tempe-

Fig. 336.



Chronic Abscess of the Lower Jaw.

rament or syphilitic taint. Large portions of the bone, along with the corresponding teeth, were often destroyed by this cause in this country, when mercury used to be given with such a profuse and daring hand. I have known cases, where, from the effects of salivation, more than one-half of the bone perished and finally sloughed away. The inflammation which precedes and accompanies the necrosis frequently involves the soft parts, producing extensive mortification, and the most horrible deformity of the features. Another bad effect is the permanent closure of the jaw by the new inodular tissues, which are generally not only extremely firm, but exhibit the same tendency to contraction as the inodular tissues of a burn. The poor sufferer, in consequence, is often unable to move the bone in the slightest degree, except, perhaps, a little, laterally, and he has the greatest difficulty in feeding himself. I have seen many cases in which the power of mastication was utterly destroyed, and where the food was obliged to be chopped as finely as possible before it could even be introduced into the mouth. Articulation, of course, is impeded, and the patient, if young, must necessarily suffer in his education.

Necrosis is always easily distinguished by the denuded state and whitish appearance of the affected bone, by the existence of purulent discharge, and by the excessively fetid state of the breath. The part, when struck with the probe, emits a peculiar ringing sound, very different from that of healthy bone.

The treatment consists in attention to cleanliness and the removal of the sequester. To fulfil the first intention, free use is made of chlorinated washes, along with such remedies as may have a tendency to improve the general health. The dead bone may be withdrawn with the fingers, or, with the fingers and forceps, the latter being always handled with the greatest care and gentleness. When the piece is very large, the operator may be compelled, as a preliminary step, to cut the gum, or even to divide the dead bone itself with the saw or pliers, but an external incision will seldom be required in any case, however extensive. When the whole of the lower jaw is necrosed, the proper procedure is to divide it at the chin, and to draw out each half separately, the knife being employed wherever it may be necessary on account of the resistance of the soft structures. When these precautions are used, and the operation is postponed until the sequestration is entirely, or at least measurably, completed, I feel satisfied that there will seldom be any need of interfering with the skin. The whole lower jaw, affected with necrosis, was thus removed by Dr. George McClellan in 1823.

4. *Phosphorus Disease*.—Within the last twenty-five years, the attention of the profession has been called to a singular species of necrosis of the lower jaw dependent upon the injurious effects of the fumes of phosphorus in the manufacture of lucifer matches. In this country, it was first noticed by Dr. James R. Wood, who gave an account of it in the *New York Journal of Medicine* for May, 1856, accompanied by the history of a case in which he removed the entire lower maxillary bone for the cure of this disease. In order to produce its specific impression, it would seem to be necessary that the vapor should come in immediate contact with the periosteum, or the alveolar process of the bone; hence it is alleged that those only who have carious teeth are liable to suffer from it. There are, however, some pathologists who assert that the phosphorus is absorbed into the system, and that its effect upon the jaw is altogether secondary, acting very much in the same manner as mercury. However this may be, the disease is essentially inflammatory, and gradually terminates in a loss of vitality, sometimes so extensive as to involve the entire bone. Its approaches are usually slow and insidious, the parts feeling merely somewhat tender and painful, as so often happens in slight toothache. The disease, in fact, is at first quite subacute. By and by, however, it acquires new activity, and then rapidly accomplishes its work, the local and constitutional disturbance being excessive, especially if abscesses form, and the mortification extend to the soft parts. Under such circumstances, it is not uncommon for the patient to die.

Of 91 cases of this affection, observed by Von Bibra, Billroth, and Salter, both jaws were affected in 5, the lower in 49, and the upper in 37. What is remarkable is that, while the inferior bone is not unfrequently involved in its entire extent, in the superior the necrosis is generally limited to the alveolar border or to this border and the palatine process.

The treatment of the disease, in its earlier stages, is the same as in periostitis from any other cause; by leeches, incisions, astringent and detergent lotions, and

general antiphlogistic means. Tonics will be demanded when there is profuse supuration, or when the mortification extends to the soft parts. In the latter case, the best topical remedy will be dilute nitric acid, acid nitrate of mercury, or nitrate of silver, with chlorinated washes.

Surgical interference is required when the dead bone has become measurably detached; it may be removed entire, or piecemeal, according to circumstances. In general, the operation may be satisfactorily performed without any external incision, even when the whole bone is involved, as in an instance reported by Dr. Charles S. Boker, of this city. Dr. William Hunt has, in a similar manner, removed nearly the entire bone. When the periosteum remains intact, the jaw may be almost completely reproduced, as in the interesting cases recorded by Geist, Billroth, Thomas Smith, and others.

5. *Deformity*.—A very unseemly deformity of the lower jaw is occasionally produced by an elongated condition of it; it is generally caused by the dragging exerted upon the bone by the vicious cicatrice of a burn, or by the pressure of some tumor, as a hypertrophied tongue, but instances occur in which it is congenital. The change produced in the position of the front teeth by the habit of sucking the thumb in childhood is well known. The enlargement is generally, if not always, associated with a peculiar oblique or horizontal direction of the jaw and teeth. Besides the disfigurement which it occasions, such a defect is necessarily attended with more or less inconvenience in mastication, and in the retention of the saliva. For the milder forms of this deformity, especially in young subjects, systematic compression sometimes answers a good purpose, made, as first suggested by Professor Humphry, of Cambridge, with a belt of India-rubber, attached to a suitable head-piece, and passed around the chin in such a manner as to bear more or less firmly upon the elongated and depressed portion of the bone. When this treatment fails, the ingenious operation devised by Dr. Hullihen, of Virginia, consisting in the excision of a V-shaped portion of the bone on each side, may be resorted to. In one case in which this was done, the result was most gratifying, although the distortion had been unusually great.

6. *Anchylosis of the Jaw*.—This distressing affection, which may be produced in a variety of ways, may exist in such a degree as to render the patient entirely unable to open his mouth or to masticate his food. The most common cause, according to my observation, is profuse ptyalism, followed by gangrene of the cheeks, lips, and jaw, and the formation of a firm, dense, unyielding inodular tissue, by which the lower jaw is closely and tightly pressed against the upper. Such an occurrence used to be extremely frequent in our Southwestern States, during the prevalence of the calomel practice, as it was termed, but is now, fortunately, rapidly diminishing. Children, of a delicate, strumous constitution, worn out by the conjoint influence of mercury and scarlatina, measles, or typhoid fever, are its most common victims; but I have also seen many examples of it in adults and elderly subjects. In the worst cases, there is always extensive perforation of the cheeks, permitting a constant escape of the saliva, and inducing the most disgusting disfigurement.

Secondly, the affection may depend upon injury, as a severe sprain or concussion, or arthritic inflammation, leading to a deposit of plastic matter, and the conversion of this substance into cellulo-fibrous, cartilaginous, or osseous tissue. I have met with a number of such cases; several in very young subjects.

Thirdly, the immobility is occasionally produced by a kind of osseous bridge, extending from the lower to the upper jaw, or from the lower jaw to the temporal bone. Such an occurrence, however, is uncommon, and is chiefly met with in persons who have suffered from chronic articular arthritis.

Finally, immobility of the jaw may be caused by the pressure of a neighboring tumor, especially if it occupy the parotid region, so as to make a direct impression upon the temporo-maxillary joint.

However induced, the effect is not only inconvenient, seriously interfering with mastication and articulation, but is often followed, especially if it occur early in life, by a stunted development of the jaw, exhibiting itself in marked shortening of the chin, and in an oblique direction of the front teeth. When complicated with perforation of the cheek and destruction of the lips, the patient has little or no control over his saliva, and is so horribly deformed as to render him an object at once of the deepest disgust and the warmest sympathy.

Treatment.—The treatment of this affection must depend upon the nature and situation of the exciting cause. When the difficulty is in the joint, occasioned by the formation of fibrous bands, the only thing that can be done is to break up the adhesions, upon the same principle as in ankylosis of any other joint. For this purpose, the patient being thoroughly influenced by chloroform, the jaw is forcibly depressed, either by a wedge made of hard wood, or by the instrument sketched in fig. 337, depicted by Scultetus, in his well-known work, the *Armamentarium Chirurgicum*, and reintroduced to the notice of the profession by Dr. Mott. Constructed on the lever and screw principle, it may be employed with great advantage in nearly all cases of ankylosis of the jaw, not only for breaking up the adhesions within the articulation, but also for maintaining the separation afterwards. Owing to the remarkable tendency in the parts to reunite, the instrument must be daily used for many months, if not for several years. Meanwhile, sorbefacient lotions should frequently be rubbed over the joints, and every precaution taken to keep down inflammation.

The annexed sketch, fig. 338, exhibits an instrument, which, as a mere lever for separating the jaw, and breaking up morbid adhesions, is superior to that of Scultetus, which it closely resembles in its mode of action. It diffuses its pressure more widely and equably over the teeth, and is, therefore, less liable to fracture and dislocate them.

When the immobility depends upon the presence of inodular tissue, the proper remedy is excision of the offending substance, an operation which is both tedious, painful, and bloody, and, unfortunately, not often followed by any but the most transient relief, owing to the tendency in the parts to reproduce the adhesions, however carefully and thoroughly they may have been removed. There is the same remarkable disposition in these cases to the contraction and regeneration of the inodular tissue as in burns and scalds. During my residence in Kentucky, I had a large share of such cases, and, although I never failed to make the most thorough work, not unfrequently repeating the operation several times at intervals of a few months, very few of them were permanently relieved. After the excision is effected, the patient must make constant use of the wedge, wearing it for months and years, so as to counteract the tendency to reclosure. Any pieces of dead bone, and loose or ill-placed teeth that may be present, should always be removed prior to the operation upon the soft parts.

Immobility of the lower jaw, caused by the formation of an osseous bridge, connecting this piece with the upper jaw, may be remedied by the removal of the adventitious substance, by means of the saw and pliers. Sometimes, however, such a procedure is rendered inexpedient, on account of the long duration and excessive firmness of the ankylosis, and the large quantity of the new osseous tissue.

When the closure is of long standing, it occasionally becomes necessary to divide the masseter muscles, as they are often found, when this is the case, to be permanently contracted. The operation, performed, of course, subcutaneously, requires some care, lest important vessels should be divided.

When the ankylosis depends upon the presence of strong cicatricial tissue, a useful degree of motion may frequently be obtained by the removal of a small section of the lower jaw immediately in front of the contraction. Such an operation, originally suggested by Professor Esmarch, has been repeatedly performed with very excellent results, the first successful case having occurred in the hands of Dr. Wilms, of Berlin, in 1858. Mr. Heath, in his *Prize Essay on the Diseases and Injuries of the Jaw*, has collected a number of examples, including several of his own, in which the operation has been performed by Continental and British surgeons. The object in removing a portion of bone is to establish a false joint; and, although, if proper care be not taken, the chasm in the bone may ultimately be filled up with new osseous

Fig. 337.



Scultetus's Lever for Separating the Jaws.

Fig. 338.



Lever for Separating the Jaws.

removal. The head and shoulders should be well elevated, and the face inclined towards the opposite side. Very few persons, whatever may be their courage or fortitude, can bear the shock and fatigue of an undertaking of such magnitude in the sitting posture. This precaution is the more necessary if chloroform be given, as I always do in such cases. I am aware that objections have been urged against the administration of this remedy in operations on the mouth, but without, I believe, any just reason. Be this as it may, I have employed this agent, ever since its introduction into practice, in all the amputations, both of the upper and lower jaw, that have fallen under my observation, and I have certainly, thus far, had no cause to regret it. The mouth can always be easily cleared of blood, even if the patient is unconscious, with the finger, or a sponge-mop.

I have never found it necessary, in any of my operations on the upper jaw, to secure the carotid artery, as a means of preventing hemorrhage. Indeed, it is surprising that such a procedure should ever have been recommended, much less practised, by any one. My experience is that there are no structures in the body, of the same extent, in their natural and diseased condition, the removal of which is attended with so little hemorrhage. No skilful surgeon now even employs compression of the carotid artery in these operations, and, as to tying that vessel as a means of security against loss of blood, nothing, it seems to me, could be more absurd and unnecessary. The chief danger from hemorrhage is in the subcutaneous arteries, especially the facial and its branches, and these are always readily controlled by the ligature. The deep-seated arteries, involved in tumors of the upper jaw, seldom bleed much, if care be taken to keep beyond the limits of the diseased tissues. If this precaution be neglected, the hemorrhage may be copious, if not exhausting. The oozing which takes place from the osseous surface, after the exsection is completed, generally speedily ceases of its own accord from the contact merely of the air; when it does not, it is usually easily arrested by compresses wet with a saturated solution of subsulphate of iron. The actual cautery can only be required when the vessel is inaccessible to the ligature, or when a portion of the disease has unfortunately been left behind.

In operations upon the upper jaw, unattended with loss of the alveolar and palatine processes, the escape of blood into the throat may generally be effectually prevented by previous plugging of the posterior nares.

The direction, extent, and number of the incisions through the soft parts must necessarily vary with the situation and volume of the tumor. In all these respects, much must be left, in every case, to the judgment and experience of the operator. When the morbid growth is comparatively limited, and seated upon the anterior, or antero-lateral, aspect of the jaw, we shall generally be able to dispense with external incisions altogether, as the object may readily be accomplished simply by dissecting off the lip from its attachments to the bone, and holding it out of the way with a finger or blunt hook. The surface of the tumor having thus been thoroughly denuded, the bone is attacked with the pliers, and severed fairly beyond the line of the disease. By this procedure, which is admirably adapted to the more simple forms of morbid growths, the operation is divested of much of its severity, and not followed by any deformity of the features, save what results from the caving in of the integument.

When the tumor involves the body of the jaw, and is of considerable bulk, the plan which I usually adopt, is to make one long, curvilinear incision, extending across the most prominent part of the tumor, from the commissure of the lips towards the zygomatic process of the malar bone, terminating within a few lines, half an inch, or an inch, of the external angle of the eye, according to the exigencies of the case. In this manner are formed two flaps, the upper of which is convex, and the lower concave, which are then carefully dissected up by bold and rapid strokes of the knife, and held out of the way by trustworthy assistants, who, at the same time, take care to compress the bleeding vessels. The space which this procedure affords is, in general, quite sufficient for the easy removal of the entire tumor, however large or extensive its connections. In my own cases, it has always answered the purpose most thoroughly. Should it, however, be inadequate, it can readily be increased to the requisite extent by carrying the knife horizontally along the inferior border of the orbit, as far over as the nose, as exhibited in fig. 331, from a patient affected with encephaloid disease of the antrum, whom I attended with Professor Pancoast. In making the first of these incisions, the facial artery is neces-

sarily divided, and, in the second, the superior maxillary nerve, together with many of the branches of the portio dura of the seventh pair. In consequence of the injury thus sustained, the parts supplied by these nerves remain a long time paralyzed, although ultimately the face regains, in great degree, its accustomed power and expression.

When the tumor, or enlargement, occupies the anterior and upper portion of the jaw, the external incision may extend vertically upwards by the side of the nose, from the free border of the lip to a level with the orbit of the eye. This will enable the operator to detach the wing of the nose, and to remove, if necessary, the ascending process of the jaw-bone, the lachrymal bone, the inferior turbinated bone, and even the vomer, as I have been compelled to do in several instances.

When the antrum is mainly implicated in the disease, two incisions, representing the form of an inverted T, are necessary, the vertical limb corresponding with the ascending process of the maxillary bone, and the horizontal one with the inferior border of the orbit of the eye. When the tumor is not very large, access may readily be obtained by making a vertical incision through the upper lip, and dissecting away the ala of the nose, as practised by O'Farrall, Syme, and other surgeons; a method which I have myself repeatedly followed with great advantage as it respects the resulting scar.

Whatever may be the form and direction of the incisions, care should be taken that they are sufficiently extensive to afford ready access to the diseased mass. Nothing can be more embarrassing, or display greater defect of judgment in the operator, than a want of room in a case of this kind.

The necessary incisions having been made, and the flaps dissected up, the next step is to remove the tumor. As a preliminary measure, two teeth, one in front and the other behind, must be extracted, to make room for the play of the saw and other instruments. As a general rule, this part of the operation should be performed as soon as the patient is fairly under the influence of chloroform, and, consequently, prior to the division of the soft structures. If done after that, it is liable to occasion delay and annoyance.

The separation of the jaw is generally the work of a few minutes. The limits of the disease being usually well defined, care must be taken to keep on the outside of them, for the twofold purpose of avoiding hemorrhage and removing the whole of the morbid structures. The best contrivance for executing this part of the operation is a pair of pliers. The surgeon should supply himself with at least three of such instruments, of different shapes and sizes, figs. 332, 333, 334, as one is rarely sufficient for the purpose. He should also have several chisels, small saws, a lenticular, and a stout scalpel, the handle of which should terminate in a steel point, that it may be used as a scraper and a cutter, as may be found most expedient.

When it is designed to remove the entire jaw, the saw or pliers should be successively carried through the alveolar process in front, and the horizontal plate behind, close to the middle line, as far back as the corresponding portion of the palate bone, the mucous membrane of the roof of the mouth having been previously divided with the scalpel, to prevent it from being bruised and lacerated. Next, the instrument is to be applied to the malar bone, at or near its junction with the maxillary, and, finally, to the nasal process, which is generally divided on a level with the lower margin of the orbit. The orbital plate of the jaw-bone is commonly left intact, at least in part, as it rarely participates in the morbid action. Should it do so, however, it should be cautiously removed with the chisel and knife, lest the eye and its appendages be injured. All that now remains to be done is to

Fig. 331.



Lines indicating the Course of the Knife in Excision of the Upper Jaw.

Fig. 332.



Fig. 333.



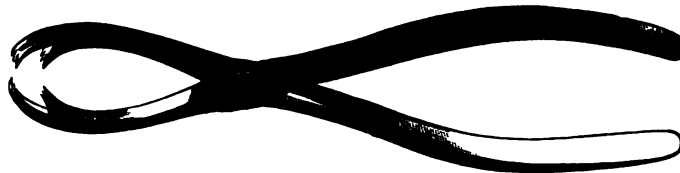
Fig. 334.



Different Forms of Bone-forceps.

sever the tumor at its junction with the pterygoid process and palate bone; and here, again, the chisel and knife will come into excellent play. Occasionally the bones, after having been pretty well divided, may be forcibly wrenched from their bed by grasping them firmly with the lion forceps of Fergusson, represented in fig. 335. The main tumor having been removed, the parts are carefully sponged, and any remnants of diseased substance that may appear are cleared away with the lenticular, gouge, and other suitable instruments.

Fig. 335.



Clawed Forceps.

It is seldom that more than three or four ligatures will be needed. To stop the oozing of blood from the deep portion of the wound, and counteract the sinking in of the cheek, the bony gap should be well stuffed with lint, wet with a saturated solution of subsulphate of iron. The external wound is closed with the twisted suture, and supported by a compress, secured by a roller, passed around the head and chin in the form of the figure 8.

When the tumor is attached to the base of the skull, or skull and posterior nares, as it may be when it is of a fibrous or sarcomatous nature, the operation is one of great difficulty, and in more than one instance the patient has rapidly sunk from the effects of shock and hemorrhage.

Excision of the entire upper jaw is not dangerous. I have performed it upwards of a dozen times without a single loss. Of 17 cases, collected by Hutchinson, from the practice of the London Hospitals, 14 were successful; and of 10 operations performed by Esmarch the result was equally flattering in 8. The tables of Heyfelder show that death ensued 26 times in 112 complete excisions of one jaw, and 36 times in 187 partial excisions. Of 9 excisions of both bones, 4 either died or the disease recurred at an early date.

Excision of both superior maxillary bones was originally performed, in 1844, by Dr. J. F. Heyfelder, on account of carcinoma. The operation has since been repeated by Maisonneuve, Deitz, Jüngken, Rogers, Langenbeck, and other surgeons. Dieffenbach, in 1848, removed the greater part of both upper jaw-bones, along with the palate and malar bones. Should such an operation be necessary, access to the diseased structures could readily be obtained by two curvilinear incisions, extending from the commissures of the lip to within a short distance of the outer angle of the eyes.

The after-treatment is strictly antiphlogistic; and, as the great danger to be apprehended is erysipelas, every means should be used to avert its occurrence. The pins are removed at the end of the third or fourth day, when the edges of the incision will generally be found to be perfectly united. I have repeatedly seen wounds, eight and nine inches in length, close by the first intention after these operations. The patient soon becomes accustomed to his loss; and the function of deglutition, at first so difficult and annoying, is gradually performed with its original facility. Even the faculty of mastication is regained much more rapidly than one, unacquainted with the compensating powers of nature, might be led to suppose. The deformity of the face is often comparatively trifling; and the defect in the mouth may usually be remedied, in the more favorable cases, by artificial means. It is surprising how much, even in a short time, the cavern contracts, and how all the surrounding and associated parts accommodate themselves to their new relations.

When the tumor is carcinomatous, it will be sure to return, sooner or later, in almost every instance, however thoroughly it may have been extirpated. In the non-malignant formations, on the contrary, there is no reason to apprehend a relapse, any more than in the same class of affections in other parts of the body.

TUMORS OF THE SPHENO-MAXILLARY FOSSA.

As a kind of an appendix to morbid growths of the upper jaw, I may here briefly describe what are called tumors of the sphenomaxillary fossa, a subject discussed with much care by Professor Langenbeck, of Berlin.

These tumors may be of various kinds, as the fibrous, vascular, osseous, sarcomatous, and carcinomatous, all of which are capable of acquiring a considerable bulk, and of penetrating, during their development, the base of the skull, and thus destroying life. Their diagnosis is, therefore, of the greatest importance, especially as they may be easily and safely removed in the earlier stages of their existence.

The precise point of origin of these morbid growths is variable; in general, they spring from the pterygoid process of the sphenoid bone, from the body of this bone, or from the superior maxilla. However this may be, they always advance, at first, in the direction of the least resistance, which is above and below the malar bone, where they, consequently, soon slightly elevate the cheek and temple. In time, they cover the whole exterior of the upper jaw, distend the temporal fossa, and penetrate the orbit through the sphenomaxillary fissure, pushing the ball of the eye upwards and somewhat forwards. They also gradually force their way through the sphenopalatine foramen into the posterior nares, driving the mucous membrane before them, and thus occasioning more or less obstruction of the nose. The facial portion of the morbid growth usually presents a remarkably constricted appearance, owing to the situation of the malar bone. The resistance of the pterygoid fascia effectually prevents the tumor from descending into the cervical region. Severe pain is generally experienced, especially when the mass is of large size, and, in that event, there is also great difficulty in opening the mouth.

The fibrous tumor of the sphenomaxillary fossa is characterized by its slow development and great firmness; the vascular, by its softness, by its deceptive sense of fluctuation, and by its marked diminution under pressure. The osseous tumor, besides being rare, grows very tardily, and seldom attains a large bulk. Its great feature is its excessive hardness. The carcinomatous tumor is distinguished here, as everywhere else, by the rapidity of its formation, by its unequal consistence, and by the great volume which it is capable of attaining. Perforation of the cranium cannot be diagnosticated with certainty, inasmuch as it may occur without inducing any symptoms. Youth and middle age are the periods of life most liable to these different morbid growths.

The extirpation of these tumors can only be effectually accomplished by the removal of the greater portion of the malar bone with the saw or pliers. The incisions through the integument should be shaped in such a manner as that, while they afford free access to the morbid mass, they may not lead to any undue deformity. The temporal muscle must, of course, be divided, either partially or completely. The attachment of the growth is usually by a comparatively small pedicle. No serious embarrassment need be anticipated from hemorrhage, especially if the tumor be kept free from the knife.

In the case of an old woman, under the charge of Dr. P. Heron Watson, of Edinburgh, in 1868, in which a large fibrous growth occupied the pterygo-buccal region, extirpation was successfully effected, with hardly any loss of blood, by an incision carried from the free margin of the lip to the mental prominence, and thence along the base of the bone to the lobe of the ear, after which the lower jaw was divided opposite the bicuspid tooth, and turned out nearly at a right angle with the zygoma, so as to expose the pterygoid region and the greater portion of the tumor, which was then carefully liberated from its attachments to the muscles of the jaw and pharynx, the carotid arteries, internal jugular vein, and the deep cervical nerves. After the large wound was sponged out, and the bleeding checked, the jaw was restored to its natural position, the severed ends being connected together by silver wire. Rapid recovery ensued.

SECT. II.—AFFECTIONS OF THE INFERIOR MAXILLARY BONE.

The lower jaw-bone is subject to various affections, of which the principal are abscess, caries, necrosis, and different kinds of tumors.

1. *Chronic Abscess.*—The lower jaw, like other bones, is liable to the formation of a circumscribed abscess, small in size, slow in its progress, lined by a distinct membrane, and filled with thick matter, the affected tissue being much increased in bulk and density. The disease, observed chiefly in young subjects, may be caused by external injury, by cold, by the action of phosphorus, or by the irritation of decayed teeth. The symptoms are generally obscure, the most prominent being a gradual enlargement of a particular portion of the bone, with a sense of excessive hardness, more or less tenderness on pressure, and fits of acute pain, recurring at variable intervals, with difficulty of separating the jaw and of masticating, and gradual failure of the health. The treatment consists in exposing the abscess with

the trephine and evacuating its contents. If the textural lesions are very great, complete excision of the affected parts may be necessary.

Fig. 336 exhibits the ramus of the left lower jaw, which, along with the coronoid process, was the seat of a central abscess. Under the supposition that it was a solid growth—for there were no symptoms pointing to suppuration—I removed it by disarticulation and resection, when it was found to contain nearly three ounces of thick matter. The inner wall of the bone above the attachment of the internal pterygoid muscle was porous and covered by thickened periosteum, while the outer plate was normal. The interior of the abscess was lined by a membrane. The patient, nineteen years of age, had received a blow at the seat of the disease twelve months previously.

2. *Caries.*—Caries of this bone does not require any particular notice, as it is neither frequent in its occurrence, nor peculiar in its character. Various causes may induce it, as external injury, the irritation of a decayed tooth, mercurialization, or a scorbutic, strumous, or syphilitic taint of the system. Whenever it takes place, the nature of the exciting cause should, if possible, be traced out, and the case treated accordingly.

3. *Necrosis.*—Necrosis is also uncommon, being witnessed principally as a result of profuse pyalism, especially in young and weakly persons, of a strumous tempe-

Fig. 336.



Chronic Abscess of the Lower Jaw.

rament or syphilitic taint. Large portions of the bone, along with the corresponding teeth, were often destroyed by this cause in this country, when mercury used to be given with such a profuse and daring hand. I have known cases, where, from the effects of salivation, more than one-half of the bone perished and finally sloughed away. The inflammation which precedes and accompanies the necrosis frequently involves the soft parts, producing extensive mortification, and the most horrible deformity of the features. Another bad effect is the permanent closure of the jaw by the new inodular tissues, which are generally not only extremely firm, but exhibit the same tendency to contraction as the inodular tissues of a burn. The poor sufferer, in consequence, is often unable to move the bone in the slightest degree, except, perhaps, a little, laterally, and he has the greatest difficulty in feeding himself. I have seen many cases in which the power of mastication was utterly destroyed, and where the food was obliged to be chopped as finely as possible before it could even be introduced into the mouth. Articulation, of course, is impeded, and the patient, if young, must necessarily suffer in his education.

Necrosis is always easily distinguished by the denuded state and whitish appearance of the affected bone, by the existence of purulent discharge, and by the excessively fetid state of the breath. The part, when struck with the probe, emits a peculiar ringing sound, very different from that of healthy bone.

The treatment consists in attention to cleanliness and the removal of the sequester. To fulfil the first intention, free use is made of chlorinated washes, along with such remedies as may have a tendency to improve the general health. The dead bone may be withdrawn with the fingers, or, with the fingers and forceps, the latter being always handled with the greatest care and gentleness. When the piece is very large, the operator may be compelled, as a preliminary step, to cut the gum, or even to divide the dead bone itself with the saw or pliers, but an external incision will seldom be required in any case, however extensive. When the whole of the lower jaw is necrosed, the proper procedure is to divide it at the chin, and to draw out each half separately, the knife being employed wherever it may be necessary on account of the resistance of the soft structures. When these precautions are used, and the operation is postponed until the sequestration is entirely, or at least measurably, completed, I feel satisfied that there will seldom be any need of interfering with the skin. The whole lower jaw, affected with necrosis, was thus removed by Dr. George McClellan in 1823.

4. *Phosphorus Disease*.—Within the last twenty-five years, the attention of the profession has been called to a singular species of necrosis of the lower jaw dependent upon the injurious effects of the fumes of phosphorus in the manufacture of lucifer matches. In this country, it was first noticed by Dr. James R. Wood, who gave an account of it in the *New York Journal of Medicine* for May, 1856, accompanied by the history of a case in which he removed the entire lower maxillary bone for the cure of this disease. In order to produce its specific impression, it would seem to be necessary that the vapor should come in immediate contact with the periosteum, or the alveolar process of the bone; hence it is alleged that those only who have carious teeth are liable to suffer from it. There are, however, some pathologists who assert that the phosphorus is absorbed into the system, and that its effect upon the jaw is altogether secondary, acting very much in the same manner as mercury. However this may be, the disease is essentially inflammatory, and gradually terminates in a loss of vitality, sometimes so extensive as to involve the entire bone. Its approaches are usually slow and insidious, the parts feeling merely somewhat tender and painful, as so often happens in slight toothache. The disease, in fact, is at first quite subacute. By and by, however, it acquires new activity, and then rapidly accomplishes its work, the local and constitutional disturbance being excessive, especially if abscesses form, and the mortification extend to the soft parts. Under such circumstances, it is not uncommon for the patient to die.

Of 91 cases of this affection, observed by Von Bibra, Billroth, and Salter, both jaws were affected in 5, the lower in 49, and the upper in 37. What is remarkable is that, while the inferior bone is not unfrequently involved in its entire extent, in the superior the necrosis is generally limited to the alveolar border or to this border and the palatine process.

The treatment of the disease, in its earlier stages, is the same as in periostitis from any other cause; by leeches, incisions, astringent and detergent lotions, and

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The treatment consists in attention to cleanliness and the removal of the sequester. To fulfil the first intention, free use is made of chlorinated washes, along with such remedies as may have a tendency to improve the general health. The dead bone may be withdrawn with the fingers, or, with the fingers and forceps, the latter being always handled with the greatest care and gentleness. When the piece is very large, the operator may be compelled, as a preliminary step, to cut the gum, or even to divide the dead bone itself with the saw or pliers, but an external incision will seldom be required in any case, however extensive. When the whole of the lower jaw is necrosed, the proper procedure is to divide it at the chin, and to draw out each half separately, the knife being employed wherever it may be necessary on account of the resistance of the soft structures. When these precautions are used, and the operation is postponed until the sequestration is entirely, or at least measurably, completed, I feel satisfied that there will seldom be any need of interfering with the skin. The whole lower jaw, affected with necrosis, was thus removed by Dr. George McClellan in 1823.

4. *Phosphorus Disease*.—Within the last twenty-five years, the attention of the profession has been called to a singular species of necrosis of the lower jaw dependent upon the injurious effects of the fumes of phosphorus in the manufacture of lucifer matches. In this country, it was first noticed by Dr. James R. Wood, who gave an account of it in the *New York Journal of Medicine* for May, 1856, accompanied by the history of a case in which he removed the entire lower maxillary bone for the cure of this disease. In order to produce its specific impression, it would seem to be necessary that the vapor should come in immediate contact with the periosteum, or the alveolar process of the bone; hence it is alleged that those only who have carious teeth are liable to suffer from it. There are, however, some pathologists who assert that the phosphorus is absorbed into the system, and that its effect upon the jaw is altogether secondary, acting very much in the same manner as mercury. However this may be, the disease is essentially inflammatory, and gradually terminates in a loss of vitality, sometimes so extensive as to involve the entire bone. Its approaches are usually slow and insidious, the parts feeling merely somewhat tender and painful, as so often happens in slight toothache. The disease, in fact, is at first quite subacute. By and by, however, it acquires new activity, and then rapidly accomplishes its work, the local and constitutional disturbance being excessive, especially if abscesses form, and the mortification extend to the soft parts. Under such circumstances, it is not uncommon for the patient to die.

Of 91 cases of this affection, observed by Von Bibra, Billroth, and Salter, both jaws were affected in 5, the lower in 49, and the upper in 37. What is remarkable is that, while the inferior bone is not unfrequently involved in its entire extent, in the superior the necrosis is generally limited to the alveolar border or to this border and the palatine process.

The treatment of the disease, in its earlier stages, is the same as in periostitis from any other cause; by leeches, incisions, astringent and detergent lotions, and

general antiphlogistic means. Tonics will be demanded when there is profuse supuration, or when the mortification extends to the soft parts. In the latter case, the best topical remedy will be dilute nitric acid, acid nitrate of mercury, or nitrate of silver, with chlorinated washes.

Surgical interference is required when the dead bone has become measurably detached; it may be removed entire, or piecemeal, according to circumstances. In general, the operation may be satisfactorily performed without any external incision, even when the whole bone is involved, as in an instance reported by Dr. Charles S. Boker, of this city. Dr. William Hunt has, in a similar manner, removed nearly the entire bone. When the periosteum remains intact, the jaw may be almost completely reproduced, as in the interesting cases recorded by Geist, Billroth, Thomas Smith, and others.

5. *Deformity*.—A very unseemly deformity of the lower jaw is occasionally produced by an elongated condition of it; it is generally caused by the dragging exerted upon the bone by the vicious cicatrice of a burn, or by the pressure of some tumor, as a hypertrophied tongue, but instances occur in which it is congenital. The change produced in the position of the front teeth by the habit of sucking the thumb in childhood is well known. The enlargement is generally, if not always, associated with a peculiar oblique or horizontal direction of the jaw and teeth. Besides the disfigurement which it occasions, such a defect is necessarily attended with more or less inconvenience in mastication, and in the retention of the saliva. For the milder forms of this deformity, especially in young subjects, systematic compression sometimes answers a good purpose, made, as first suggested by Professor Humphry, of Cambridge, with a belt of India-rubber, attached to a suitable head-piece, and passed around the chin in such a manner as to bear more or less firmly upon the elongated and depressed portion of the bone. When this treatment fails, the ingenious operation devised by Dr. Hüllihen, of Virginia, consisting in the excision of a V-shaped portion of the bone on each side, may be resorted to. In one case in which this was done, the result was most gratifying, although the distortion had been unusually great.

6. *Anchylosis of the Jaw*.—This distressing affection, which may be produced in a variety of ways, may exist in such a degree as to render the patient entirely unable to open his mouth or to masticate his food. The most common cause, according to my observation, is profuse ptyalism, followed by gangrene of the cheeks, lips, and jaw, and the formation of a firm, dense, unyielding inodular tissue, by which the lower jaw is closely and tightly pressed against the upper. Such an occurrence used to be extremely frequent in our Southwestern States, during the prevalence of the calomel practice, as it was termed, but is now, fortunately, rapidly diminishing. Children, of a delicate, strumous constitution, worn out by the conjoint influence of mercury and scarlatina, measles, or typhoid fever, are its most common victims; but I have also seen many examples of it in adults and elderly subjects. In the worst cases, there is always extensive perforation of the cheeks, permitting a constant escape of the saliva, and inducing the most disgusting disfigurement.

Secondly, the affection may depend upon injury, as a severe sprain or concussion, or arthritic inflammation, leading to a deposit of plastic matter, and the conversion of this substance into cellulo-fibrous, cartilaginous, or osseous tissue. I have met with a number of such cases; several in very young subjects.

Thirdly, the immobility is occasionally produced by a kind of osseous bridge, extending from the lower to the upper jaw, or from the lower jaw to the temporal bone. Such an occurrence, however, is uncommon, and is chiefly met with in persons who have suffered from chronic articular arthritis.

Finally, immobility of the jaw may be caused by the pressure of a neighboring tumor, especially if it occupy the parotid region, so as to make a direct impression upon the temporo-maxillary joint.

However induced, the effect is not only inconvenient, seriously interfering with mastication and articulation, but is often followed, especially if it occur early in life, by a stunted development of the jaw, exhibiting itself in marked shortening of the chin, and in an oblique direction of the front teeth. When complicated with perforation of the cheek and destruction of the lips, the patient has little or no control over his saliva, and is so horribly deformed as to render him an object at once of the deepest disgust and the warmest sympathy.

Treatment.—The treatment of this affection must depend upon the nature and situation of the exciting cause. When the difficulty is in the joint, occasioned by the formation of fibrous bands, the only thing that can be done is to break up the adhesions, upon the same principle as in ankylosis of any other joint. For this purpose, the patient being thoroughly influenced by chloroform, the jaw is forcibly depressed, either by a wedge made of hard wood, or by the instrument sketched in fig. 337, depicted by Scultetus, in his well-known work, the *Armamentarium Chirurgicum*, and reintroduced to the notice of the profession by Dr. Mott. Constructed on the lever and screw principle, it may be employed with great advantage in nearly all cases of ankylosis of the jaw, not only for breaking up the adhesions within the articulation, but also for maintaining the separation afterwards. Owing to the remarkable tendency in the parts to reunite, the instrument must be daily used for many months, if not for several years. Meanwhile, sorbefacient lotions should frequently be rubbed over the joints, and every precaution taken to keep down inflammation.

Fig. 337.



Scultetus's Lever for Separating the Jaws.

The annexed sketch, fig. 338, exhibits an instrument, which, as a mere lever for separating the jaw, and breaking up morbid adhesions, is superior to that of Scultetus, which it closely resembles in its mode of action. It diffuses its pressure more widely and equably over the teeth, and is, therefore, less liable to fracture and dislocate them.

Fig. 338.



Lever for Separating the Jaws.

When the immobility depends upon the presence of inodular tissue, the proper remedy is excision of the offending substance, an operation which is both tedious, painful, and bloody, and, unfortunately, not often followed by any but the most transient relief, owing to the tendency in the parts to reproduce the adhesions, however carefully and thoroughly they may have been removed. There is the same remarkable disposition in these cases to the contraction and regeneration of the inodular tissue as in burns and scalds. During my residence in Kentucky, I had a large share of such cases, and, although I never failed to make the most thorough work, not unfrequently repeating the operation several times at intervals of a few months, very few of them were permanently relieved. After the excision is effected, the patient must make constant use of the wedge, wearing it for months and years, so as to counteract the tendency to reclosure. Any pieces of dead bone, and loose or ill-placed teeth that may be present, should always be removed prior to the operation upon the soft parts.

Immobility of the lower jaw, caused by the formation of an osseous bridge, connecting this piece with the upper jaw, may be remedied by the removal of the adventitious substance, by means of the saw and pliers. Sometimes, however, such a procedure is rendered inexpedient, on account of the long duration and excessive firmness of the ankylosis, and the large quantity of the new osseous tissue.

When the closure is of long standing, it occasionally becomes necessary to divide the masseter muscles, as they are often found, when this is the case, to be permanently contracted. The operation, performed, of course, subcutaneously, requires some care, lest important vessels should be divided.

When the ankylosis depends upon the presence of strong cicatricial tissue, a useful degree of motion may frequently be obtained by the removal of a small section of the lower jaw immediately in front of the contraction. Such an operation, originally suggested by Professor Esmarch, has been repeatedly performed with very excellent results, the first successful case having occurred in the hands of Dr. Wilms, of Berlin, in 1858. Mr. Heath, in his *Prize Essay on the Diseases and Injuries of the Jaw*, has collected a number of examples, including several of his own, in which the operation has been performed by Continental and British surgeons. The object in removing a portion of bone is to establish a false joint; and, although, if proper care be not taken, the chasm in the bone may ultimately be filled up with new osseous

tissue, the relief afforded is so marked that, if it be regarded merely as a temporary expedient, the procedure is one which no surgeon should hesitate to undertake. Professor Rizzoli, of Bologna, instead of cutting out a section, simply divides the bone. His first operation was performed in 1857, and he subsequently had three other successful cases. In none of these cases was there any external incision, the section of the jaw having been effected with powerful forceps within the mouth. It is hardly necessary to say that the operation of Esmarch is decidedly preferable to that of the Italian surgeon, as holding out a better chance of permanent relief. Simple division of the bone is more especially adapted to cases of contraction within the mouth without loss of substance of the cheek.

For the cure of ankylosis of the temporo-maxillary articulation, one of two things may be done—neither, it must be confessed, very promising, nor easy of execution—either to exsect the condyle of the jaw at the joint, or to cut through the ramus underneath the masseter muscle. Grube, in 1863, in a case of complete ankylosis, broke the neck of the bone by means of a straight chisel introduced through the mouth, and effected a cure by the formation of a false joint, the treatment having been materially facilitated by the subcutaneous division of the masseter muscle some months subsequent to the original operation. It has been proposed, when both condyles are firmly ankylosed, to remove the entire jaw, but such a procedure would not only be ruthless but unnecessary, as the patient can generally contrive to articulate and feed himself without much trouble even when the teeth are pretty firmly locked.

The gap in the cheek, left by salivation, and so often accompanying closure of the jaw, may be filled up by a flap borrowed from the neighboring integument, and carefully stitched in place. The adjoining sketches, figs. 339, 340, exhibit the manner of performing such an operation.

Fig. 339.



Fig. 340.



Plastic Operation on the Cheek.

7. *Tumors.*—Morbid growths of the lower jaw are more common than those of the superior maxilla, and spring either from the interior of the bone, its surface, or its alveolar border, constituting, in the last situation, epulides, which may be fibrous, sarcomatous, or carcinomatous, and do not differ, in any respect, from those of the upper jaw. Whether peripheral or central, they generally attain much larger dimensions than corresponding tumors of the superior maxilla, the sarcomatous and cartilaginous, especially, giving rise to hideous deformity, projecting on the sides and front of the neck, and into, and almost filling, the mouth and pharynx, widely separating the jaws, stretching the mouth, displacing the tongue, and pressing upon the epiglottis, thereby interfering with, if not finally abolishing, articulation, mastication, deglutition, and respiration.

From its superficial relations and its isolated position, tumors of the lower jaw are more readily diagnosed than those of the other bones of the face. When they arise in the interior of the body or ramus, they are usually inclosed in a bony or periosteal case, or a capsule composed of both structures, which is developed principally at the

expense of the external surface of the bone, the projection on the inner side being comparatively insignificant. This osseous shell, which surrounds the smaller growths, is somewhat loosely referred, even in standard works, to expansion of the plates of the bone, but this is an error, inasmuch as the cancellous and compact structures are absorbed, at the same time that the new osseous material, which furnishes the cyst-wall, is poured out by the soft layer of the periosteum. In the larger tumors, the periosteum ceases to proliferate, so that the inclosing capsule is for the greater part membranous. It is best marked in the cystic, myeloid, and cystic cartilaginous tumors, and is usually so thin as to fluctuate at some points, and crackle like parchment at others. The periosteal or peripheral tumors, on the other hand, are not provided with a bony capsule, but it is not at all uncommon to find them pervaded by osseous spicules and plates, giving rise to the so-called osteoid fibromas, carcinomas, and sarcomas.

The carcinomatous tumors of the lower jaw may readily be distinguished from the innocent formations by their progressive, rapid, and painful growth; by their soft, pulpy, or elastic feel; by the early involvement of the submaxillary glands, with adhesion to, and infiltration of, the surrounding parts; by the enlargement of the subcutaneous veins; by early ulceration and the appearance of fungous masses either at the exterior or at the alveolar border of the bone; and by the usual signs of constitutional contamination. Sarcomatous tumors develop more slowly, but, when once aroused into action, their growth is more rapid, and they soon attain a greater bulk. Their consistence is, equally with carcinoma, usually soft and elastic, but all of the other signs are wanting, although ulceration may set in late. Even that portion of a central sarcoma which makes its way into the mouth through absorption of the alveolar border of the bone, is not the seat of central ulceration. The sore, if present at all, is due either to overstretching of the mucous membrane, or external causes, and is superficial and non-fungating.

Tumors of all descriptions, with the exception of gelatinoid polyps, are more commonly seated in and on the lower than the upper jaw. The following statistics of 403 cases, compiled by Weber, show the relative frequency of their occurrence, although the number of examples of carcinoma, doubtless from errors in diagnosis, is too large, while that of sarcoma is too small: Carcinoma, 162; sarcoma, 132; osteoma, 25; cystoma, 25; fibroma, 23; osteoid chondroma, 18; enchondroma, 14; angioma, 2; and melanotic sarcoma and carcinoma, 2.

a. *Cystic Tumors*.—The cystic tumor of the lower jaw is usually seated in the alveolar border of the bone, and resembles, in every particular, the alveolar cyst of the superior maxilla. It not unfrequently arises within the substance of the bone, where it may attain the volume of an orange; but, in this situation, it differs from cystic disease of the antrum in originating in the cancellous structure of the bone, and not in the glandular follicles of a lining mucous membrane. As the anatomy and symptoms of the central cystic tumor of the lower jaw do not differ from those of cystic disease of the alveolar border of the upper jaw, they do not require further consideration here.

It is seldom that this tumor requires removal of the affected bone. In general, it will suffice to puncture it occasionally with a small trocar, to evacuate its contents, the escape of which is often followed by the rapid contraction and ultimate obliteration of the sac. Something, too, may be done, in such cases, by graduated compression. When there is a strong tendency to reaccumulation, a large opening may be made, and a tent inserted; or the necessary inflammation may be provoked by injections of weak solutions of iodine. It is only in old and intractable cases that excision of the bone, at the site of the disease, will be likely to be required. Dr. J. Mason Warren, in 1866, published the particulars of two cases of this affection, going to show that, even when the tumor is of considerable size, a cure may gradually be effected by puncturing the cyst within the mouth, cutting away a portion of its wall, and then pressing the opposite sides forcibly together with the fingers.

The disease to which writers at one time so generally applied the vague and unmeaning terms *osteosarcoma* and *spina ventosa*, is an exaggerated form of the tumor just described, but usually due to mucoid softening and cystic degeneration of myeloid formations. It is by far the most common of the benign growths of the lower jaw. Appearing at all periods of life, it is most frequent in young adults, and is capable of acquiring an immense magnitude. Several instances have fallen under my observation in which its volume was so great as to cause the most hideous and

removal. The head and shoulders should be well elevated, and the face inclined towards the opposite side. Very few persons, whatever may be their courage or fortitude, can bear the shock and fatigue of an undertaking of such magnitude in the sitting posture. This precaution is the more necessary if chloroform be given, as I always do in such cases. I am aware that objections have been urged against the administration of this remedy in operations on the mouth, but without, I believe, any just reason. Be this as it may, I have employed this agent, ever since its introduction into practice, in all the amputations, both of the upper and lower jaw, that have fallen under my observation, and I have certainly, thus far, had no cause to regret it. The mouth can always be easily cleared of blood, even if the patient is unconscious, with the finger, or a sponge-mop.

I have never found it necessary, in any of my operations on the upper jaw, to secure the carotid artery, as a means of preventing hemorrhage. Indeed, it is surprising that such a procedure should ever have been recommended, much less practised, by any one. My experience is that there are no structures in the body, of the same extent, in their natural and diseased condition, the removal of which is attended with so little hemorrhage. No skilful surgeon now even employs compression of the carotid artery in these operations, and, as to tying that vessel as a means of security against loss of blood, nothing, it seems to me, could be more absurd and unnecessary. The chief danger from hemorrhage is in the subcutaneous arteries, especially the facial and its branches, and these are always readily controlled by the ligature. The deep-seated arteries, involved in tumors of the upper jaw, seldom bleed much, if care be taken to keep beyond the limits of the diseased tissues. If this precaution be neglected, the hemorrhage may be copious, if not exhausting. The oozing which takes place from the osseous surface, after the exsection is completed, generally speedily ceases of its own accord from the contact merely of the air; when it does not, it is usually easily arrested by compresses wet with a saturated solution of sub-sulphate of iron. The actual cautery can only be required when the vessel is inaccessible to the ligature, or when a portion of the disease has unfortunately been left behind.

In operations upon the upper jaw, unattended with loss of the alveolar and palatine processes, the escape of blood into the throat may generally be effectually prevented by previous plugging of the posterior nares.

The direction, extent, and number of the incisions through the soft parts must necessarily vary with the situation and volume of the tumor. In all these respects, much must be left, in every case, to the judgment and experience of the operator. When the morbid growth is comparatively limited, and seated upon the anterior, or antero-lateral, aspect of the jaw, we shall generally be able to dispense with external incisions altogether, as the object may readily be accomplished simply by dissecting off the lip from its attachments to the bone, and holding it out of the way with a finger or blunt hook. The surface of the tumor having thus been thoroughly denuded, the bone is attacked with the pliers, and severed fairly beyond the line of the disease. By this procedure, which is admirably adapted to the more simple forms of morbid growths, the operation is divested of much of its severity, and not followed by any deformity of the features, save what results from the caving in of the integument.

When the tumor involves the body of the jaw, and is of considerable bulk, the plan which I usually adopt, is to make one long, curvilinear incision, extending across the most prominent part of the tumor, from the commissure of the lips towards the zygomatic process of the malar bone, terminating within a few lines, half an inch, or an inch, of the external angle of the eye, according to the exigencies of the case. In this manner are formed two flaps, the upper of which is convex, and the lower concave, which are then carefully dissected up by bold and rapid strokes of the knife, and held out of the way by trustworthy assistants, who, at the same time, take care to compress the bleeding vessels. The space which this procedure affords is, in general, quite sufficient for the easy removal of the entire tumor, however large or extensive its connections. In my own cases, it has always answered the purpose most thoroughly. Should it, however, be inadequate, it can readily be increased to the requisite extent by carrying the knife horizontally along the inferior border of the orbit, as far over as the nose, as exhibited in fig. 331, from a patient affected with encephaloid disease of the antrum, whom I attended with Professor Pancoast. In making the first of these incisions, the facial artery is neces-

sarily divided, and, in the second, the superior maxillary nerve, together with many of the branches of the portio dura of the seventh pair. In consequence of the injury thus sustained, the parts supplied by these nerves remain a long time paralyzed, although ultimately the face regains, in great degree, its accustomed power and expression.

When the tumor, or enlargement, occupies the anterior and upper portion of the jaw, the external incision may extend vertically upwards by the side of the nose, from the free border of the lip to a level with the orbit of the eye. This will enable the operator to detach the wing of the nose, and to remove, if necessary, the ascending process of the jaw-bone, the lachrymal bone, the inferior turbinated bone, and even the vomer, as I have been compelled to do in several instances.

When the antrum is mainly implicated in the disease, two incisions, representing the form of an inverted T, are necessary, the vertical limb corresponding with the ascending process of the maxillary bone, and the horizontal one with the inferior border of the orbit of the eye. When the tumor is not very large, access may readily be obtained by making a vertical incision through the upper lip, and dissecting away the ala of the nose, as practised by O'Farrall, Syme, and other surgeons; a method which I have myself repeatedly followed with great advantage as it respects the resulting scar.

Whatever may be the form and direction of the incisions, care should be taken that they are sufficiently extensive to afford ready access to the diseased mass. Nothing can be more embarrassing, or display greater defect of judgment in the operator, than a want of room in a case of this kind.

The necessary incisions having been made, and the flaps dissected up, the next step is to remove the tumor. As a preliminary measure, two teeth, one in front and the other behind, must be extracted, to make room for the play of the saw and other instruments. As a general rule, this part of the operation should be performed as soon as the patient is fairly under the influence of chloroform, and, consequently, prior to the division of the soft structures. If done after that, it is liable to occasion delay and annoyance.

The separation of the jaw is generally the work of a few minutes. The limits of the disease being usually well defined, care must be taken to keep on the outside of them, for the twofold purpose of avoiding hemorrhage and removing the whole of the morbid structures. The best contrivance for executing this part of the operation is a pair of pliers. The surgeon should supply himself with at least three of such instruments, of different shapes and sizes, figs. 332, 333, 334, as one is rarely sufficient for the purpose. He should also have several chisels, small saws, a lenticular, and a stout scalpel, the handle of which should terminate in a steel point, that it may be used as a scraper and a cutter, as may be found most expedient.

When it is designed to remove the entire jaw, the saw or pliers should be successively carried through the alveolar process in front, and the horizontal plate behind, close to the middle line, as far back as the corresponding portion of the palate bone, the mucous membrane of the roof of the mouth having been previously divided with the scalpel, to prevent it from being bruised and lacerated. Next, the instrument is to be applied to the malar bone, at or near its junction with the maxillary, and, finally, to the nasal process, which is generally divided on a level with the lower margin of the orbit. The orbital plate of the jaw-bone is commonly left intact, at least in part, as it rarely participates in the morbid action. Should it do so, however, it should be cautiously removed with the chisel and knife, lest the eye and its appendages be injured. All that now remains to be done is to

Fig. 331.



Lines indicating the Course of the Knife in Excision of the Upper Jaw.

Fig. 332.



Fig. 333.



Fig. 334.



Different Forms of Bone-forceps.

sever the tumor at its junction with the pterygoid process and palate bone; and here, again, the chisel and knife will come into excellent play. Occasionally the bones, after having been pretty well divided, may be forcibly wrenched from their bed by grasping them firmly with the lion forceps of Fergusson, represented in fig. 335. The main tumor having been removed, the parts are carefully sponged, and any remnants of diseased substance that may appear are cleared away with the lenticular, gouge, and other suitable instruments.

Fig. 335.



Clawed Forceps.

It is seldom that more than three or four ligatures will be needed. To stop the oozing of blood from the deep portion of the wound, and counteract the sinking in of the cheek, the bony gap should be well stuffed with lint, wet with a saturated solution of subsulphate of iron. The external wound is closed with the twisted suture, and supported by a compress, secured by a roller, passed around the head and chin in the form of the figure 8.

When the tumor is attached to the base of the skull, or skull and posterior nares, as it may be when it is of a fibrous or sarcomatous nature, the operation is one of great difficulty, and in more than one instance the patient has rapidly sunk from the effects of shock and hemorrhage.

Excision of the entire upper jaw is not dangerous. I have performed it upwards of a dozen times without a single loss. Of 17 cases, collected by Hutchinson, from the practice of the London Hospitals, 14 were successful; and of 10 operations performed by Esmarch the result was equally flattering in 8. The tables of Heyfelder show that death ensued 26 times in 112 complete excisions of one jaw, and 36 times in 187 partial excisions. Of 9 excisions of both bones, 4 either died or the disease recurred at an early date.

Excision of both superior maxillary bones was originally performed, in 1844, by Dr. J. F. Heyfelder, on account of carcinoma. The operation has since been repeated by Maisonneuve, Deitz, Jüngken, Rogers, Langenbeck, and other surgeons. Dieffenbach, in 1848, removed the greater part of both upper jaw-bones, along with the palate and malar bones. Should such an operation be necessary, access to the diseased structures could readily be obtained by two curvilinear incisions, extending from the commissures of the lip to within a short distance of the outer angle of the eyes.

The after-treatment is strictly antiphlogistic; and, as the great danger to be apprehended is erysipelas, every means should be used to avert its occurrence. The pins are removed at the end of the third or fourth day, when the edges of the incision will generally be found to be perfectly united. I have repeatedly seen wounds, eight and nine inches in length, close by the first intention after these operations. The patient soon becomes accustomed to his loss; and the function of deglutition, at first so difficult and annoying, is gradually performed with its original facility. Even the faculty of mastication is regained much more rapidly than one, unacquainted with the compensating powers of nature, might be led to suppose. The deformity of the face is often comparatively trifling; and the defect in the mouth may usually be remedied, in the more favorable cases, by artificial means. It is surprising how much, even in a short time, the cavern contracts, and how all the surrounding and associated parts accommodate themselves to their new relations.

When the tumor is carcinomatous, it will be sure to return, sooner or later, in almost every instance, however thoroughly it may have been extirpated. In the non-malignant formations, on the contrary, there is no reason to apprehend a relapse, any more than in the same class of affections in other parts of the body.

TUMORS OF THE SPHENO-MAXILLARY FOSSA.

As a kind of an appendix to morbid growths of the upper jaw, I may here briefly describe what are called tumors of the sphenomaxillary fossa, a subject discussed with much care by Professor Langenbeck, of Berlin.

These tumors may be of various kinds, as the fibrous, vascular, osseous, sarcomatous, and carcinomatous, all of which are capable of acquiring a considerable bulk, and of penetrating, during their development, the base of the skull, and thus destroying life. Their diagnosis is, therefore, of the greatest importance, especially as they may be easily and safely removed in the earlier stages of their existence.

The precise point of origin of these morbid growths is variable; in general, they spring from the pterygoid process of the sphenoid bone, from the body of this bone, or from the superior maxilla. However this may be, they always advance, at first, in the direction of the least resistance, which is above and below the malar bone, where they, consequently, soon slightly elevate the cheek and temple. In time, they cover the whole exterior of the upper jaw, distend the temporal fossa, and penetrate the orbit through the sphenomaxillary fissure, pushing the ball of the eye upwards and somewhat forwards. They also gradually force their way through the sphenopalatine foramen into the posterior nares, driving the mucous membrane before them, and thus occasioning more or less obstruction of the nose. The facial portion of the morbid growth usually presents a remarkably constricted appearance, owing to the situation of the malar bone. The resistance of the pterygoid fascia effectually prevents the tumor from descending into the cervical region. Severe pain is generally experienced, especially when the mass is of large size, and, in that event, there is also great difficulty in opening the mouth.

The fibrous tumor of the sphenomaxillary fossa is characterized by its slow development and great firmness; the vascular, by its softness, by its deceptive sense of fluctuation, and by its marked diminution under pressure. The osseous tumor, besides being rare, grows very tardily, and seldom attains a large bulk. Its great feature is its excessive hardness. The carcinomatous tumor is distinguished here, as everywhere else, by the rapidity of its formation, by its unequal consistence, and by the great volume which it is capable of attaining. Perforation of the cranium cannot be diagnosticated with certainty, inasmuch as it may occur without inducing any symptoms. Youth and middle age are the periods of life most liable to these different morbid growths.

general antiphlogistic means. Tonics will be demanded when there is profuse supuration, or when the mortification extends to the soft parts. In the latter case, the best topical remedy will be dilute nitric acid, acid nitrate of mercury, or nitrate of silver, with chlorinated washes.

Surgical interference is required when the dead bone has become measurably detached; it may be removed entire, or piecemeal, according to circumstances. In general, the operation may be satisfactorily performed without any external incision, even when the whole bone is involved, as in an instance reported by Dr. Charles S. Boker, of this city. Dr. William Hunt has, in a similar manner, removed nearly the entire bone. When the periosteum remains intact, the jaw may be almost completely reproduced, as in the interesting cases recorded by Geist, Billroth, Thomas Smith, and others.

5. *Deformity*.—A very unseemly deformity of the lower jaw is occasionally produced by an elongated condition of it; it is generally caused by the dragging exerted upon the bone by the vicious cicatrice of a burn, or by the pressure of some tumor, as a hypertrophied tongue, but instances occur in which it is congenital. The change produced in the position of the front teeth by the habit of sucking the thumb in childhood is well known. The enlargement is generally, if not always, associated with a peculiar oblique or horizontal direction of the jaw and teeth. Besides the disfigurement which it occasions, such a defect is necessarily attended with more or less inconvenience in mastication, and in the retention of the saliva. For the milder forms of this deformity, especially in young subjects, systematic compression sometimes answers a good purpose, made, as first suggested by Professor Humphry, of Cambridge, with a belt of India-rubber, attached to a suitable head-piece, and passed around the chin in such a manner as to bear more or less firmly upon the elongated and depressed portion of the bone. When this treatment fails, the ingenious operation devised by Dr. Hullihen, of Virginia, consisting in the excision of a V-shaped portion of the bone on each side, may be resorted to. In one case in which this was done, the result was most gratifying, although the distortion had been unusually great.

6. *Anchyllosis of the Jaw*.—This distressing affection, which may be produced in a variety of ways, may exist in such a degree as to render the patient entirely unable to open his mouth or to masticate his food. The most common cause, according to my observation, is profuse ptyalism, followed by gangrene of the cheeks, lips, and jaw, and the formation of a firm, dense, unyielding inodular tissue, by which the lower jaw is closely and tightly pressed against the upper. Such an occurrence used to be extremely frequent in our Southwestern States, during the prevalence of the calomel practice, as it was termed, but is now, fortunately, rapidly diminishing. Children, of a delicate, strumous constitution, worn out by the conjoint influence of mercury and scarlatina, measles, or typhoid fever, are its most common victims; but I have also seen many examples of it in adults and elderly subjects. In the worst cases, there is always extensive perforation of the cheeks, permitting a constant escape of the saliva, and inducing the most disgusting disfigurement.

Secondly, the affection may depend upon injury, as a severe sprain or concussion, or arthritic inflammation, leading to a deposit of plastic matter, and the conversion of this substance into cellulo-fibrous, cartilaginous, or osseous tissue. I have met with a number of such cases; several in very young subjects.

Thirdly, the immobility is occasionally produced by a kind of osseous bridge, extending from the lower to the upper jaw, or from the lower jaw to the temporal bone. Such an occurrence, however, is uncommon, and is chiefly met with in persons who have suffered from chronic articular arthritis.

Finally, immobility of the jaw may be caused by the pressure of a neighboring tumor, especially if it occupy the parotid region, so as to make a direct impression upon the temporo-maxillary joint.

However induced, the effect is not only inconvenient, seriously interfering with mastication and articulation, but is often followed, especially if it occur early in life, by a stunted development of the jaw, exhibiting itself in marked shortening of the chin, and in an oblique direction of the front teeth. When complicated with perforation of the cheek and destruction of the lips, the patient has little or no control over his saliva, and is so horribly deformed as to render him an object at once of the deepest disgust and the warmest sympathy.

Treatment.—The treatment of this affection must depend upon the nature and situation of the exciting cause. When the difficulty is in the joint, occasioned by the formation of fibrous bands, the only thing that can be done is to break up the adhesions, upon the same principle as in ankylosis of any other joint. For this purpose, the patient being thoroughly influenced by chloroform, the jaw is forcibly depressed, either by a wedge made of hard wood, or by the instrument sketched in fig. 337, depicted by Scultetus, in his well-known work, the *Armamentarium Chirurgicum*, and reintroduced to the notice of the profession by Dr. Mott. Constructed on the lever and screw principle, it may be employed with great advantage in nearly all cases of ankylosis of the jaw, not only for breaking up the adhesions within the articulation, but also for maintaining the separation afterwards. Owing to the remarkable tendency in the parts to reunite, the instrument must be daily used for many months, if not for several years. Meanwhile, sorbefacient lotions should frequently be rubbed over the joints, and every precaution taken to keep down inflammation.

Fig. 337.



Scultetus's Lever for Separating the Jaws.

The annexed sketch, fig. 338, exhibits an instrument, which, as a mere lever for separating the jaw, and breaking up morbid adhesions, is superior to that of Scultetus, which it closely resembles in its mode of action. It diffuses its pressure more widely and equably over the teeth, and is, therefore, less liable to fracture and dislocate them.

Fig. 338.



Lever for Separating the Jaws.

When the immobility depends upon the presence of inodular tissue, the proper remedy is excision of the offending substance, an operation which is both tedious, painful, and bloody, and, unfortunately, not often followed by any but the most transient relief, owing to the tendency in the parts to reproduce the adhesions, however carefully and thoroughly they may have been removed. There is the same remarkable disposition in these cases to the contraction and regeneration of the inodular tissue as in burns and scalds. During my residence in Kentucky, I had a large share of such cases, and, although I never failed to make the most thorough work, not unfrequently repeating the operation several times at intervals of a few months, very few of them were permanently relieved. After the excision is effected, the patient must make constant use of the wedge, wearing it for months and years, so as to counteract the tendency to reclosure. Any pieces of dead bone, and loose or ill-placed teeth that may be present, should always be removed prior to the operation upon the soft parts.

Immobility of the lower jaw, caused by the formation of an osseous bridge, connecting this piece with the upper jaw, may be remedied by the removal of the adventitious substance, by means of the saw and pliers. Sometimes, however, such a procedure is rendered inexpedient, on account of the long duration and excessive firmness of the ankylosis, and the large quantity of the new osseous tissue.

When the closure is of long standing, it occasionally becomes necessary to divide the masseter muscles, as they are often found, when this is the case, to be permanently contracted. The operation, performed, of course, subcutaneously, requires some care, lest important vessels should be divided.

When the ankylosis depends upon the presence of strong cicatricial tissue, a useful degree of motion may frequently be obtained by the removal of a small section of the lower jaw immediately in front of the contraction. Such an operation, originally suggested by Professor Esmarch, has been repeatedly performed with very excellent results, the first successful case having occurred in the hands of Dr. Wilms, of Berlin, in 1858. Mr. Heath, in his *Prize Essay on the Diseases and Injuries of the Jaw*, has collected a number of examples, including several of his own, in which the operation has been performed by Continental and British surgeons. The object in removing a portion of bone is to establish a false joint; and, although, if proper care be not taken, the chasm in the bone may ultimately be filled up with new osseous

structure of the bone, or in the periosteum; or it may originate in the mucous glands of the gum and palate, and involve the bone secondarily. In the first case, it generally progresses until it fills up the whole sinus, after which it encroaches upon the bony parietes of the cavity, pushing them out in every direction, and thereby pressing them against the surrounding structures. As the external wall is extremely thin, in fact a mere shell, in the natural state, the morbid growth commonly advances more rapidly in this direction than in any other, forming thus, frequently at an early stage, quite a large tumor on the cheek. By and by, as it proceeds in its development, it extends towards the nostril, partially, and sometimes completely, occluding the corresponding cavity; upwards towards the floor of the orbit, compressing and ultimately protruding the ball of the eye, or even penetrating the skull through the ethmoid bone; downwards towards the palate, displacing the tongue, and diminishing the mouth; and backwards towards the fauces, impeding mastication, deglutition, speech, and respiration. At this stage of the disease the countenance is most hideously disfigured, and the patient is an object well calculated to excite commiseration. The appearances here described are well seen in figs. 329 and 330.

Fig. 329.



Carcinoma of the Antrum, Encroaching upon the Face.

Fig. 330.



Carcinoma of the Antrum, Encroaching upon the Mouth.

The overlying integument and mucous membrane are generally sound in the earlier stages of the complaint; but after a certain period, varying from several months to a year, they assume a livid and congested appearance, and at length yield to ulcerative action. The consequence is a fungating and rapidly spreading sore, the seat of a thin, sanious, muco-purulent, or sanguinolent discharge, very abundant, excessively fetid, and highly irritating. Pure blood often proceeds from it; sometimes very small in quantity, at other times so copious as rapidly to undermine the strength, and bring on hectic fever, with exhausting night-sweats.

In the later stages of the disease, when ulceration has set in, the lymphatic glands of the temple, behind the ear, and under the jaw, occasionally become enlarged and contaminated, and finally give way from over-distention. This immunity of the glands is peculiar to carcinomatous diseases of the upper jaw, doubtless for the reason that the antrum is poorly supplied with lymphatic vessels. The countenance assumes a peculiar cadaverous expression; the patient rapidly loses flesh and strength; colliquative diarrhoea supervenes; the pain is excessive; and death finally occurs from exhaustion. The progress of the malady is variable; sometimes very rapid, at other times quite tardy. I have seen death produced by it in less than six months from its commencement; and, on the other hand, I have met with cases in which the fatal event did not take place under four years. The affection, according

to my experience, is usually more rapid here, as elsewhere, in children and youths than in the middle-aged and old.

The tumor, after removal, exhibits, under the microscope, round cells, or squamous and cylindric epithelium, contained in a soft, alveolar basis-structure. That portion which occupies the antrum is commonly very soft and pulpy, resembling, at least faintly, both in color and consistence, a section of the brain. The osseous structure is broken down and disorganized, quite vascular, and so porous as to be easily cut. In some places, and in some specimens, it is entirely, or nearly entirely, absorbed; while in others it is replaced by fibro-cartilage, or cartilage, intermixed with spicules and scales, remnants of the original tissues. In the majority of cases, the morbid growth is remarkably vascular, as it is pervaded in every direction by large vessels, the walls of which are exceedingly brittle, and, therefore, liable to yield under the slightest impulse. It is owing to this circumstance that these tumors frequently attain such an enormous bulk, and that, when ulceration sets in, they are so liable to fungate and bleed.

The diagnosis of carcinoma of the superior jaw, however commencing, is usually not difficult. The rapid growth of the tumor, its steady encroachment upon the adjacent parts, its soft and elastic feel, the livid aspect of its buccal portion, and its sharp, darting pains, readily distinguish it from all other formations. In the later stages of the affection, the fungous character of the ulcer, and the sanious, sanguinolent, or bloody discharges, together with the sallow and cadaverous state of the countenance, and the enlargement of the neighboring lymphatic glands, leave no doubt about its nature. The exploring needle will at once inform us as to the consistence of the morbid product, and the nature of its contents. If the mass have undergone the cystic degeneration, an escape of serum, or muco-sanguineous fluid, will afford the necessary intelligence, and enable us to shape our course accordingly; while, if carcinomatous matter be present, the smallest particle will, if subjected to the microscope, reveal the characteristic structure.

Carcinoma of the jaw seldom coexists with malignant disease in other parts of the body. The affection, in fact, in the great majority of instances, is more local in its character than when it invades other tissues or organs. It is, doubtless, owing to this circumstance that excision of the disease, especially in its earlier stages, when it is, as it were, incapsulated in the bone, is occasionally successful, although in general the prognosis is most unfavorable.

Carcinoma of the alveolar border of the superior maxilla, in the form of epithelioma, or, occasionally, of melanosis, usually begins in the glands of the gum, from which it gradually extends to the bone, and constitutes *carcinomatous epulis*. Arising generally in the vicinity of the molar teeth, it consists of a florid or purplish mass, with a firm, elastic base, and a coarsely granular, papillary, cleft, or cauliflower-like surface, which soon ulcerates, manifests a great tendency to bleed, and is the seat of severe pain, with a fetid, sanious discharge. The affection is peculiar to advanced life, although it has been observed by Soulé and Wützer, respectively, at the third and eleventh year. The cervical lymphatic glands almost invariably enlarge, and the constitution evinces signs of contamination, early in the disease, the duration of life from the time of its first appearance often not exceeding eight months. These features, along with the possibility of expressing a juice and a soft, cheesy substance, are sufficient to distinguish carcinomatous from fibrous and sarcomatous epulides. The prognosis of this affection, if removed in its early stages, is favorable. When, however, it has attained considerable volume, excision of the entire bone is indicated. Under these circumstances, partial extirpation will be sure to be followed by repullulation, not only at the cicatrice but also in the neighboring glands.

EXCISION OF THE UPPER JAW.

Excision of the upper jaw is required chiefly in malignant disease, and under such circumstances it may be necessary to remove, at the same time, portions of the malar, turbinated, ethmoid, and sphenoid bones, which are often involved in the morbid action. A part of the upper jaw was removed by Acoluthus, as early as 1693; but the honor of first extirpating the whole of it is due to the late Dr. Jameson, of Baltimore, who achieved the enterprise successfully in 1820.

The patient, during the operation, should always be placed recumbent, especially if the tumor is of considerable bulk, and a good deal of time is required to effect its

tissue, the relief afforded is so marked that, if it be regarded merely as a temporary expedient, the procedure is one which no surgeon should hesitate to undertake. Professor Rizzoli, of Bologna, instead of cutting out a section, simply divides the bone. His first operation was performed in 1857, and he subsequently had three other successful cases. In none of these cases was there any external incision, the section of the jaw having been effected with powerful forceps within the mouth. It is hardly necessary to say that the operation of Esmarch is decidedly preferable to that of the Italian surgeon, as holding out a better chance of permanent relief. Simple division of the bone is more especially adapted to cases of contraction within the mouth without loss of substance of the cheek.

For the cure of ankylosis of the temporo-maxillary articulation, one of two things may be done—neither, it must be confessed, very promising, nor easy of execution—either to exsect the condyle of the jaw at the joint, or to cut through the ramus underneath the masseter muscle. Grube, in 1863, in a case of complete ankylosis, broke the neck of the bone by means of a straight chisel introduced through the mouth, and effected a cure by the formation of a false joint, the treatment having been materially facilitated by the subcutaneous division of the masseter muscle some months subsequent to the original operation. It has been proposed, when both condyles are firmly ankylosed, to remove the entire jaw, but such a procedure would not only be ruthless but unnecessary, as the patient can generally contrive to articulate and feed himself without much trouble even when the teeth are pretty firmly locked.

The gap in the cheek, left by salivation, and so often accompanying closure of the jaw, may be filled up by a flap borrowed from the neighboring integument, and carefully stitched in place. The adjoining sketches, figs. 339, 340, exhibit the manner of performing such an operation.

Fig. 339.



Fig. 340.



Plastic Operation on the Cheek.

7. *Tumors.*—Morbid growths of the lower jaw are more common than those of the superior maxilla, and spring either from the interior of the bone, its surface, or its alveolar border, constituting, in the last situation, epulides, which may be fibrous, sarcomatous, or carcinomatous, and do not differ, in any respect, from those of the upper jaw. Whether peripheral or central, they generally attain much larger dimensions than corresponding tumors of the superior maxilla, the sarcomatous and cartilaginous, especially, giving rise to hideous deformity, projecting on the sides and front of the neck, and into, and almost filling, the mouth and pharynx, widely separating the jaws, stretching the mouth, displacing the tongue, and pressing upon the epiglottis, thereby interfering with, if not finally abolishing, articulation, mastication, deglutition, and respiration.

From its superficial relations and its isolated position, tumors of the lower jaw are more readily diagnosed than those of the other bones of the face. When they arise in the interior of the body or ramus, they are usually inclosed in a bony or periosteal case, or a capsule composed of both structures, which is developed principally at the

expense of the external surface of the bone, the projection on the inner side being comparatively insignificant. This osseous shell, which surrounds the smaller growths, is somewhat loosely referred, even in standard works, to expansion of the plates of the bone, but this is an error, inasmuch as the cancellous and compact structures are absorbed, at the same time that the new osseous material, which furnishes the cyst-wall, is poured out by the soft layer of the periosteum. In the larger tumors, the periosteum ceases to proliferate, so that the inclosing capsule is for the greater part membranous. It is best marked in the cystic, myeloid, and cystic cartilaginous tumors, and is usually so thin as to fluctuate at some points, and crackle like parchment at others. The periosteal or peripheral tumors, on the other hand, are not provided with a bony capsule, but it is not at all uncommon to find them pervaded by osseous spicules and plates, giving rise to the so-called osteoid fibromas, carcinomas, and sarcomas.

The carcinomatous tumors of the lower jaw may readily be distinguished from the innocent formations by their progressive, rapid, and painful growth; by their soft, pulpy, or elastic feel; by the early involvement of the submaxillary glands, with adhesion to, and infiltration of, the surrounding parts; by the enlargement of the subcutaneous veins; by early ulceration and the appearance of fungous masses either at the exterior or at the alveolar border of the bone; and by the usual signs of constitutional contamination. Sarcomatous tumors develop more slowly, but, when once aroused into action, their growth is more rapid, and they soon attain a greater bulk. Their consistence is, equally with carcinoma, usually soft and elastic, but all of the other signs are wanting, although ulceration may set in late. Even that portion of a central sarcoma which makes its way into the mouth through absorption of the alveolar border of the bone, is not the seat of central ulceration. The sore, if present at all, is due either to overstretching of the mucous membrane, or external causes, and is superficial and non-fungating.

Tumors of all descriptions, with the exception of gelatinoid polyps, are more commonly seated in and on the lower than the upper jaw. The following statistics of 403 cases, compiled by Weber, show the relative frequency of their occurrence, although the number of examples of carcinoma, doubtless from errors in diagnosis, is too large, while that of sarcoma is too small: Carcinoma, 162; sarcoma, 132; osteoma, 25; cystoma, 25; fibroma, 23; osteoid chondroma, 18; enchondroma, 14; angioma, 2; and melanotic sarcoma and carcinoma, 2.

a. Cystic Tumors.—The cystic tumor of the lower jaw is usually seated in the alveolar border of the bone, and resembles, in every particular, the alveolar cyst of the superior maxilla. It not unfrequently arises within the substance of the bone, where it may attain the volume of an orange; but, in this situation, it differs from cystic disease of the antrum in originating in the cancellous structure of the bone, and not in the glandular follicles of a lining mucous membrane. As the anatomy and symptoms of the central cystic tumor of the lower jaw do not differ from those of cystic disease of the alveolar border of the upper jaw, they do not require further consideration here.

It is seldom that this tumor requires removal of the affected bone. In general, it will suffice to puncture it occasionally with a small trocar, to evacuate its contents, the escape of which is often followed by the rapid contraction and ultimate obliteration of the sac. Something, too, may be done, in such cases, by graduated compression. When there is a strong tendency to reaccumulation, a large opening may be made, and a tent inserted; or the necessary inflammation may be provoked by injections of weak solutions of iodine. It is only in old and intractable cases that excision of the bone, at the site of the disease, will be likely to be required. Dr. J. Mason Warren, in 1866, published the particulars of two cases of this affection, going to show that, even when the tumor is of considerable size, a cure may gradually be effected by puncturing the cyst within the mouth, cutting away a portion of its wall, and then pressing the opposite sides forcibly together with the fingers.

The disease to which writers at one time so generally applied the vague and unmeaning terms *osteosarcoma* and *spina ventosa*, is an exaggerated form of the tumor just described, but usually due to mucoid softening and cystic degeneration of myeloid formations. It is by far the most common of the benign growths of the lower jaw. Appearing at all periods of life, it is most frequent in young adults, and is capable of acquiring an immense magnitude. Several instances have fallen under my observation in which its volume was so great as to cause the most hideous and

disgusting deformity. Always slow in its development, the tumor is free from pain, never affects the constitution, and does not return after extirpation. The most common site of it is the body of the bone, but cases occur in which nearly the whole jaw is involved. The surface of the tumor is generally lobulated, and of unequal consistence, some parts being very hard and firm, others soft and fluctuating. The subcutaneous veins are rarely much enlarged, and there is no contamination of the neighboring lymphatic glands. When the tumor is very voluminous, it may encroach seriously upon the mouth and throat, interrupting speech, mastication, and deglutition; but, commonly, it enlarges mostly at the expense of the cheek, which is often frightfully distorted in consequence. The external appearances of this form of tumor are well shown in fig. 341, from a private patient, a young man of nineteen.

Fig. 341.



Fig. 342.



Cystic Tumor of the Lower Jaw.

The structure of this growth is essentially composed of cavities, filled with various kinds of fluid, as serous, glairy, sanguineous, and purulent, surrounded and traversed by osseous spicules, and fibrous, fibro-cartilaginous, and cartilaginous septa. They vary much in size and figure, and it often happens that several communicate with each other. The adjoining cut, fig. 342, exhibits an enormous cystic tumor of the lower jaw, which I removed, some years ago, from a man upwards of forty years of age. It had been growing for sixteen years. The operation was completely successful.

The diagnosis of this disease cannot be mistaken. The tardiness of its development, its unequal consistence, its fluctuating feel, and its outward growth, together with the absence of local and general contamination, are sufficient to distinguish it from all other affections of the jaw. In cases of uncertainty, the exploring needle is employed. Sometimes the tumor, especially when composed of large cavities, sounds, on percussion, like a dice-box, a noise which is never heard in carcinoma.

Relief is afforded by excision of the diseased mass; and it is here, more particularly, that modern surgery has achieved some of its proudest triumphs. Tumors of enormous volume, and involving nearly the whole of the jaw, have been removed, again and again, successfully; and such undertakings may always be attempted the more cheerfully because of our positive conviction that there will be no repululation.

What are called *dentigerous cysts* of the jaw, depending upon the presence of undeveloped teeth, are uncommon, and cannot always be distinguished from ordinary cysts and solid tumors, although the presumption will be strongly in their favor if a certain tooth has never made its appearance at its proper situation, or has never been extracted. Their formation is almost invariably connected with the permanent teeth. The tumor is generally of tardy development, and seldom attains any great bulk. Legouest has reported a very singular case of dentigerous cyst of the lower jaw, which at one point pulsated synchronously with the radial artery, a

circumstance due to the excessive vascularity of its lining membrane. Formations of this kind are liable to suppurate, and to give rise to great suffering. The annexed sketch, fig. 343, from Heath, affords a good illustration of this species of tumor.

β. *Aneurism*.—So far as I know, only two cases of aneurism of the lower jaw have been observed; one by Ruz, and the other by Heyfelder. The tumor, in the latter, was situated at the extreme edge of the bone, below the incisor and canine teeth, had a rounded, fungous appearance, very similar to that of an epulis, bled on the slightest touch, and pulsated isochronously with the heart. The patient, thirty-two years of age, dying of cholera, the dissection revealed a large excavation of the dental canal of the horizontal ramus of the jaw, accompanied by the destruction of the interalveolar septa, and the partial displacement of the corresponding teeth. The proper remedy for such an affection, if it could be recognized during life, would be to open the tumor freely, and to plug the cavity firmly with lint steeped in a strong solution of subsulphate of iron, with a view of provoking suppurative inflammation. Should this fail, the only resource would be excision of a part of the bone.

γ. *Hematoid Tumors*.—There is a peculiar tumor of the lower jaw, which, from the nature of its structure, deserves to be designated by the term hematoid, as most expressive of its true character. I have seen only one case of it, a brief history of which will afford a sufficiently accurate idea of its anatomy, symptoms, and progress. The patient, a man, aged thirty-five, had first noticed the affection about three years before I saw him. It had made its appearance in the form of a hard, solid tubercle, not larger than a hazelnut, on the left side of the jaw, just behind the cuspid tooth. Its progress was very slow for a long time, but at length it began to increase with considerable rapidity, and became the seat of a constant, dull, aching pain. At the time of my examination, the tumor extended from the middle of the large grinder on the left side to the lateral incisor on the right, bulging forwards in such a manner as to cause considerable deformity of the chin. The corresponding teeth inclined backwards and inwards, and were so loose as to be unfit for mastication. The gum was abnormally red, and somewhat hypertrophied, but otherwise perfectly sound. There was no enlargement of the neighboring lymphatic glands, and the general health was good.

The tumor was found, after removal, to be about the volume of a medium-sized orange, and to consist of a mere osseous shell, occupied by three red, solid coagula, the largest of which did not exceed the volume of a pigeon's egg. The cavity was only partially filled by the clotted blood, which adhered to the inner surface of the bony wall, and exhibited distinct traces of organization. The man promptly recovered after the operation, and has ever since remained well.

δ. *Fibrous, Cartilaginous, and Osseous Tumors*.—These growths usually arise between the angle of the bone and the canine socket, and are capable of acquiring large dimensions, particularly the periosteal forms. The enormous bulk to which an enchondroma may attain, is well illustrated by a case referred to by Paget, in a woman, thirty-nine years of age, who had a tumor of this kind that enclosed the entire jaw, with the exception of the right ramus, and measured two feet in circumference by six inches in depth. It had been growing for eight years, during the last two of which it had become ulcerated, and finally destroyed life by inducing starvation. Ried extirpated an enchondroma which was as large as a child's head, and Wagner has described one that weighed three pounds and a half. An exostosis, of which the spongy and ivory-like forms appear to be equally frequent, rarely ever exceeds the size of a small fist, and is more slow in its progress, as well as of harder consistence, than fibroma or enchondroma. In 1851, Dr. Pinkney, of the Navy, showed me a piece of the inferior maxilla, which he had removed for a hard, firm, solid tumor, constituting partial hyperostosis of the bone, from a man at Lima, and which was so dense that he found it almost impossible to divide it with the saw. Beautiful examples of ivory-like hyperostosis have been delineated by Volkmann, O. Weber, and Heath.

Fig. 343.



Dentigerous Cyst of the Lower Jaw.

All of these tumors may readily be distinguished from malignant growths of the lower jaw, by their firm consistence, by their slow and painless progress, by the freedom from involvement of the submaxillary lymphatic glands and the superincumbent integument, by their non-fungating character, and by the non-impairment of the general health so long as the patient can respire and swallow without difficulty. The discrimination, however, between these individual tumors is not so easy. In general terms it may be said that fibrous tumors possess an ovoidal or globular form, with a uniformly smooth surface, that they are firm, but elastic to the touch, that they are most common in young adults, and that their growth is more rapid than that of cartilaginous or bony tumors. Enchondroma is distinguished by its deeply lobed outline, its occurrence in youth, its more rapid progress, its larger size, and its more dense consistence, which, however, is not uniform. The diagnosis of exostosis is based upon its smooth or nodulated surface, its uniform and excessive hardness, its greater frequency in middle aged and elderly subjects, its very tardy development, and its comparatively small bulk.

1. *Myxomatous Tumors*.—Pure myxoma of the maxillæ is rare, but it has been met with, particularly in the lower jaw, where it is developed from the medulla. It presents no characteristics by which it can be distinguished from other central growths, and is usually associated with enchondroma.

5. *Osteoid Chondromatous Tumors*.—The term osteoid chondroma has been applied by Virchow to those peripheral neoplasms which originate in the ossifying cell-layer existing between the periosteum and the surface of growing bones, and is called by him membranous or osteoid cartilage, since it forms the starting point of ossific processes, as indicated by the normal growth of bone and the development of callus, osteophytes, and other pathological formations, and, for that reason, is the equivalent of cartilage. Holding an intermediate position between osteoma and enchondroma, osteoid chondroma is made up of cells, which differ from those of cartilage in being small, fusiform, or round-oval with short prolongations, and devoid of capsules. They lie free in a very dense, striated, but non-fibrillated, sclerosed, or cartilaginous intercellular substance, which is greatly in excess of the cellular elements, although the latter may predominate, and increase in size, in which event the tumor becomes sarcomatous. On section the mass is seen to be extensively pervaded by bone, at one point fragile and porous, at another dense and hard, which forms a delicate skeleton or framework, attached to the surface of the jaw, in the interstices of which very numerous giant cells are commonly contained. In some specimens the ossific process has advanced so far as only to require the deposition of the salts of lime in the remaining softer portions of the growth to convert it into an osteoma. It is rich in bloodvessels which penetrate its very substance, in which respect it differs from enchondroma.

From the fact that osteoid chondroma is seated most frequently on the shafts of the long bones, and that it was not met with in a single instance of the 307 tumors of the superior maxilla, referred to in the preceding section, I am induced to believe that its occurrence on the lower jaw is estimated too highly in the table of Professor Weber, which indicates 18 cases in 403 neoplasms of this bone. Some pathologists, indeed, are disposed to include it among the ossifying periosteal sarcomas, from which they are unable to distinguish it, either by its minute, gross, or clinical features.

Osteoid chondroma does not possess a single element by which it may be diagnosed from periosteal sarcoma. It is most frequent in young persons; is of a firm consistence; of an ovoidal or pyriform shape, with a smooth or only slightly uneven surface; grows rapidly, and attains a large volume. Closely connected with the body of the jaw, it receives an investment from the periosteum, which, however, may finally give way, and permit the mass to infiltrate the surrounding tissues. The huge dimensions which it may acquire are well illustrated by a case under the charge of Sir Astley Cooper, in a girl, thirteen years of age, in whom the tumor, of twelve months' growth, measured sixteen inches in circumference. The tongue was pushed not only to one side but backwards into the pharynx, while the epiglottis was recurvated upon the superior aperture of the larynx, through which death finally ensued from the combined effects of starvation and respiratory embarrassment.

7. *Sarcomatous Tumors*.—The general features, symptoms, diagnosis, and treatment of sarcoma of the lower jaw, whether central or peripheral, are precisely similar to those of the superior maxilla. In this situation, however, they are of more frequent occurrence, and attain a larger volume, extending in all directions, and not

unfrequently weighing, after removal, between four and five pounds, as in the instances recorded by Syme, Heath, and other surgeons. The central or myeloid tumor is more common about the period of the second dentition, and has been observed at a very early age, as in the case of a boy of seven and a half years, under the charge of Mr. Heath, in whom the disease was first noticed when he was eighteen months old. A remarkable, and, probably, unique, feature of this case was the simultaneous involvement of both sides of the jaw, the central portion of the bone remaining intact. Mucoid softening and cystic degeneration of the myeloid tissue is met with in almost every central sarcoma, and it is sometimes so extensive as to produce the disease formerly known as *spina ventosa*.

The recurring tendency of sarcomatous *epulis*, the earlier and more advanced stages of which are delineated in figs. 344 and 345, the former from a private patient, the

Fig. 344.



Epulis, in its Earlier Stages.

Fig. 345.



Epulis, in its More Advanced Stages.

latter from Druitt, is well illustrated in the case of a man, aged fifty-nine, who came to my Clinic in November, 1870, on account of a soft, elastic, fluctuating tumor of the lower jaw, which was completely edentulous from the repeated extraction of the teeth. Its upper or free border consisted of greatly thickened and highly vascular membrane, while its lower limit was formed by the basilar portion of the bone. The disease extended, as disclosed by the operation for its removal, from the left second molar alveolus to the angle of the right jaw, the central portion of the body of the bone, elongated at the mental process, being particularly involved. The patient had never experienced pain, but the submaxillary lymphatic glands of the right side were slightly enlarged. The disease was first noticed, ten years previously, as a soft, fungoid mass, which proceeded from the lower right lateral socket, and was cut away when it had attained the size of a walnut. Speedy recurrence ensued, and, after the lapse of five years, when a second operation was performed, it involved the entire alveolar border between the second bicuspid cavities. A third operation, in which the gouge was freely used, was soon required, and it was not until two years and a half subsequent to this period that the man came under my charge, when I extirpated the bone, leaving only the left ramus and that portion of the right ramus above the attachment of the internal pterygoid muscle. The bleeding, which was excessively free, recurred in three days, and, in less than a week, carried off the patient, who was evidently laboring under the hemorrhagic diathesis. The tumor was composed of a tissue of the consistence of firm jelly, and of a greenish tint, which exhibited, under the microscope, a mixture of large spindle and giant cells, the former predominating, imbedded in a granular, intercellular substance. A more striking example of repullulation, likewise under my care, in which five operations, two being superficial, two excisions, and one a disarticulation, were performed, is detailed at page 276, vol. I., the man finally perishing from a return of the disease in the soft tissues of the cheek.

6. *Carcinomatous Tumors*.—The only forms of carcinoma of the lower jaw worthy of notice are encephaloid and epithelioma. The malady may occur here, as elsewhere, at all periods of life, encephaloid being much more frequent in childhood and adolescence than in middle age and decrepitude, when epithelioma is chiefly met with. Indeed, the very worst cases of encephaloid that I have ever witnessed, took place before the tenth year, and ran their course with a rapidity truly frightful. Most of the subjects of the disease perish within the first twelve months from the commencement of the attack; and, if an attempt be made to relieve them by operation, however early, the disease is sure to return in a very short time, either at the cicatrice

or in the adjacent structures, especially the lymphatic glands. As the symptoms, diagnosis, prognosis, and treatment of carcinoma and carcinomatous epulis of the lower jaw, do not differ, in any respect, from those of the upper jaw, any further account of them here would be superfluous.

EXCISION OF THE LOWER JAW.

Excision of the lower jaw has become a frequent operation, and it is, therefore, very important that surgeons should have accurate ideas respecting the best mode of executing it. The bone may be removed entire, or it may be divided at its middle, and disarticulated at one joint, or, lastly, a considerable portion may be cut away at its centre, body, or ramus. The first attempt at amputation of the lower jaw was made by Dr. W. H. Deadrick, of Tennessee, in 1810, upon a lad fourteen years of age. The tumor was of a cartilaginous structure, and occupied the left side of the bone, filling nearly the whole of the mouth, and causing great difficulty in swallowing, and even, at times, in breathing. An incision was commenced under the zygomatic process, and carried across the tumor, in the direction of the jaw, to nearly an inch beyond the middle of the chin. From the centre of this, and, consequently, at a right angle with it, another incision was extended a short distance down the neck. The flaps thus marked off being separated from the morbid growth, the bone was sawed off just in front of the ramus and at the centre of the chin. The wound was united in the usual manner, and the boy, who made a speedy recovery, was perfectly well thirteen years after the operation. In 1823, Dr. Mott excised nearly the whole of the inferior jaw on one side; and eighteen months after he removed all that portion of the bone included between the right temporo-maxillary joint and the bicuspid tooth on the left side. This, so far as I am aware, was the first case in which exarticulation of this bone was effected in the United States.

The entire lower jaw has been repeatedly removed, either at one operation or after a variable interval, for necrosis, the result of phosphorus disease. The first operation of the kind was performed by Signorini, and the next, in 1843, by J. F. Heyfelder, of Erlangen. The cases of Dr. Carnochan and Dr. James R. Wood are well known to American surgeons. In 1850, Professor Ackley, of Cleveland, removed the entire lower jaw on account of sarcoma, constituting, so far as my information extends, the first successful example of total excision of this bone for a morbid growth upon record. The patient survived the operation two years. Maisonneuve had a similar case in 1856.

The operation is conducted upon the same general principles as excision of the upper jaw; the patient is placed in a similar position, and is brought fully under the influence of chloroform. The external incisions are made in such a manner as to avoid the unsightly appearance resulting from a large and exposed scar. For this purpose, when it is designed to remove one-half of the bone at its articulation, the knife should, as a general rule, be carried along its base, from the zygomatic process, about three-quarters of an inch in front of the ear, to the chin, and thence some distance up the middle line, or even as high up as the red margin of the lip. When the tumor is of immense size, two incisions are sometimes required, so as to include an elliptical portion of the soft parts; but, unless this is the case, or the skin is seriously involved in the disease, not a particle of integument should be sacrificed; for during the healing process there is usually inordinate contraction, and hence, if this precaution be neglected, great deformity may be the consequence. By making the perpendicular incision in front of the ear, there will be little danger of wounding the temporal or external carotid artery and the trunk of the portio dura. Sometimes, as when the disarticulation is effected with difficulty, a short horizontal incision, just below the zygomatic process, will be advantageous; but, in general, this is unnecessary. The duct of Steno should always be avoided, as it readily may be by being careful not to carry the knife too high up, or too far forwards.

When the disease is confined to the central portion of the jaw, the best plan is to make two incisions, one extending perpendicularly from the angle of the mouth, and the other horizontally along the base of the bone, unless the tumor is very small, when it may be removed from the interior simply by detaching the lip, chin, and other soft structures from the affected mass. In severing the soft parts from their connections behind, the tongue must be firmly held with a tenaculum, otherwise, its

support being lost, it may fall back into the throat, and thus partially, if not completely, suffocate the patient. A delicate wire should afterwards be passed through the organ, and secured to the dressings, where it is retained until the tendency to retraction has ceased by the formation of new attachments, which usually takes place in five or six days from the time of the operation.

When the alveolar process alone is involved, it has been recommended that the base of the bone should be left intact, on the ground that it would serve to give support to the soft parts, and become the nucleus of a new deposit. It has even been insisted upon that, in such a case, extirpation could be easily and safely effected without any external incision, simply by detaching the lip or cheek from the jaw, and holding it out of the way during the division of the bone. Such a procedure cannot be too pointedly condemned; it does the work only half, and is sure to be speedily followed by a recurrence of the disease.

When the operation involves the removal of the jaw at the joint, the best plan is to expose the tumor as rapidly and carefully as possible, and then saw the bone at the anterior limits of the morbid mass. This greatly expedites not only the process of disarticulation, but the separation of the jaw from its muscular and mucous connections, as it enables the operator, by seizing its anterior extremity, to move the bone in any direction he pleases. Convenient saws for dividing the bone are represented in figs. 346 and 347.

Fig. 346.



Fig. 347.



Saws for dividing the Jaws.

Disarticulation of the jaw may be effected, and the whole ramus removed, as was first done by Mr. Syme, without opening the mouth. The operation consists, first, in dissecting up the parotid gland and masseter muscle; secondly, in sawing through the bone in front of the diseased mass; and, lastly, in severing the attachments of the pterygoid muscles without wounding the mucous membrane, the bone being wrenched from its socket with a pair of strong clawed forceps.

One of the most important circumstances to be observed, in exsection of the lower jaw, is to keep in close contact with the morbid structure, and yet sufficiently away from it to prevent any portion of it from being left behind. By attention to this rule, which I regard as one of paramount importance, two great ends are attained, the easy removal of the tumor by a neat and rapid dissection, and the avoidance of hemorrhage. Cutting into the tumor is almost sure to be followed by the division of large vessels, which do not fail to bleed profusely, unless checked by compression until the operation is completed. Besides, chipping off a piece here and another there generally necessitates a tedious after-section, alike painful to the patient, and annoying to the operator.

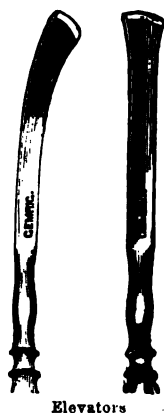
Another important rule, in these operations, is to work as much as possible with the handle instead of the edge and point of the knife, especially in detaching the bone from the soft structures. Whenever it can be done, a portion of the periosteum should be saved, and there are few cases, except in the malignant forms of tumor, in which this membrane is so thoroughly involved in the disease as to render this impracticable. The part thus rescued is of great importance afterwards in filling up the void produced by the removal of the bone, at the same time that it prevents undue injury to the other soft structures.

One of the great difficulties connected with the excision of the lower jaw is the liberation of the coronoid and condyloid process. The instrument which has always, heretofore, been employed for this purpose is the knife, or the knife and saw. The fibres of the temporal muscle, embracing the coronoid process on every side, are

directed to be cut close to their attachments, or, instead of this, the process is sawn through at its base; the structures of the temporo-maxillary articulation are always divided with the extremity of the knife, entered at any point that may be most convenient. Now, it has always appeared to me that this mode of procedure should, if possible, be avoided, as it is apt to be followed by serious hemorrhage, and by injury of important nerves. This is especially the case with regard to the separation of the condyle, lying, as it does, in close and intimate relation with the internal maxillary artery, which must necessarily be endangered by the knife in this stage of the operation. A wound of this vessel, just as the operation is about to be finished, is an embarrassing circumstance, from the difficulty of applying a ligature, and is liable to be accompanied by copious hemorrhage. The coronoid process, although it projects up some distance into the zygomatic fossa, is separated with less difficulty, and, as it lies anterior to the maxillary artery, there is little danger of interfering with this vessel. Still, a pretty smart hemorrhage occasionally results from the division simply of the little arteries of the temporal muscles.

To obviate this danger, as well as to expedite the process of disarticulation, usually, and, in truth, very justly, regarded, in the ordinary mode as no very easy part of the operation, I have used with great advantage an instrument combining the principles of a lever and a knife. The accompanying sketch, fig. 348, will convey a much better idea of it than the most elaborate description. The blade is slightly curved upon the flat, and is three inches and a quarter in length, by three-eighths of an inch in width, its thickness being about one line and a third. Its free extremity terminates in a convex edge, bevelled off in front and behind, so as to admit of being used for dividing the periosteum, or scraping the bone, as may be deemed necessary. The other extremity is set in a stout, rough handle, nearly four inches long. A perfectly straight instrument of this kind, as seen in fig. 349, may be used with much advantage. The body and ramus of the jaw being detached from their connections, the blunt edge of the elevator is insinuated beneath the fibrous covering of the coronoid process, and, after separating it for some distance, the bone is prized out. In the same manner the soft structures may be peeled from the condyle of the jaw, and the latter lifted from the glenoid cavity. The whole procedure is the work of a few seconds, and its great superiority, as was before

Fig. 348. Fig. 349.



stated, is its entire freedom from danger to the maxillary and other arteries, as well as the trunk and deep-seated branches of the portio dura. When these processes with their investing structures are perfectly sound, the separation must be effected, at least in part, with the knife, but even here the instruments above described will afford valuable aid.

The gap that is left by this operation is often filled up, especially in young subjects, by a cartilaginous formation, of an irregularly cylindrical shape, which, while it serves to support the jaw in mastication, assists materially in reestablishing the symmetry of the features. The time required for the production of this substitute varies, in different cases, from a few months to several years. Even when one-half of the bone has been removed, nature sometimes succeeds most admirably in her object. In 1832, I had an opportunity of seeing an Irish lad, seventeen years of age, from whom Dr. Cusack, of Dublin, had, four years previously, extirpated the left half of the inferior maxilla, on account of a fibro-cartilaginous affection. In this instance, nature had made an attempt at reproduction, by means of a thick, rounded piece of cartilage, sufficiently strong to subserve the ordinary purposes of mastication, which was performed with the greatest facility.

Excision of the lower jaw affords very favorable results. Of 419 cases tabulated by the late Professor O. Weber, only 83, or 20 per cent., perished. Of these, 246 were excisions in the continuity, with 46 deaths; 153 disarticulations of one-half of the bone, of which 117 recovered; and 20 extirpations of the entire jaw, with only 1 death. Pyemia, erysipelas, and exhaustion were the principal causes of death.

SECT. III.—AFFECTIONS OF THE TEETH.

The diseases of the teeth are of too frequent occurrence, and too severe in their character, to justify their exclusion altogether from a work on surgery. A knowledge of them is of great importance, particularly to the country practitioner, who, in consequence of his remoteness from the regular dentist, is often obliged to extract these organs, and to give advice in regard to their affections.

1. *Sympathies*.—The sympathetic relations of the teeth are adverted to in the first volume, in the chapter on Irritation. Their influence in inducing and maintaining ill health in the jaws, gums, eyes, ears, head, and lymphatic glands, as well as in other parts of the body, is displayed in a great variety of ways, and deserves the most careful consideration of the general practitioner. Without an intimate knowledge of their relations, he must remain ignorant of the pathology of some of the most common affections about the head and face, and be, consequently, unable to treat them upon correct scientific principles.

2. *Dentition*.—In children, during the progress of the first dentition, the surgeon is often called upon to relieve suffering on account of the pressure upon the gum by an advancing tooth, or, perhaps, more correctly speaking, the gum and the membranous cyst by which the tooth is surrounded. A great deal of irritation may thus be induced, causing not only much local distress, but occasionally, also, much disturbance in the other organs, especially the brain, stomach, and bowels. In the more severe cases, the gum is red, tumid, and tender, the mouth is hot and dry, and the child is thirsty, feverish, and restless. Not unfrequently convulsions, coma, and death follow, from arachnitis, gastritis, or enteritis, or from a combination of these diseases.

The proper remedy for difficult dentition is free division of the gums and the inclosing membrane of the advancing tooth. The operation is usually performed with what is called the gum-lancet, but a far better instrument for this purpose is the blade of an ordinary penknife, the point of which, being very narrow and sharp, is thrust down in contact with the offending tooth, which is thus at once liberated from its confined position, much to the comfort both of the parts and of the system. The head of the little patient, during the operation, is held between the surgeon's knees, an assistant having charge of the rest of the body. In dividing the gum over the large grinders, a crucial incision is usually made, whereas a single one will always answer for the incisors. Very little bleeding follows the operation, generally just enough to relieve the engorged vessels; but now and then, as happened to me in one case, many years ago, it is so copious as to prove fatal, although such an event is not to be looked for unless there is a hemorrhagic diathesis. It has been objected to this operation that, when it is not followed by the immediate extrusion of the tooth, the cicatrice that will form over it by the healing of the gum will afterwards render its eruption more difficult; but such a conclusion is altogether erroneous, as all new tissues are much more easily destroyed than old or preëxisting.

Excessive suffering is often experienced during the evolution of the *wisdom tooth*, especially that of the lower jaw, from the manner in which it is pressed upon by the gum and neighboring structures, which are too small for its comfortable accommodation. The difficulty may be caused by the want of space between the tooth and the base of the coronoid process, or by various malpositions of the tooth, the jaw itself being in every respect well formed. Thus, the tooth may be situated horizontally instead of vertically; take a wrong direction forwards, and be arrested by the adjoining grinder; project inwards against the tongue or outwards against the cheek; be concealed by an indurated, gristly gum; or, lastly, be permanently imbedded in the alveolar process of the jaw.

All these conditions are capable of giving rise to excessive irritation, often rapidly followed by the most intense inflammation. Among the earlier symptoms are, pain in the ear and temporo-maxillary joint, difficulty of motion, articulation, mastication, and deglutition, swelling of the gums, tongue, throat, face, and more or less febrile disturbance. As the disease progresses, the local suffering gradually increases, and ultimately amounts to great agony. In the more aggravated forms of the affection, the jaw is obstinately closed, the coronoid process is assailed with caries or necrosis, abscesses are developed in the neck, cheek, tonsil, and salivary glands, the tongue is enormously swollen, the breath is excessively fetid, the respiration is labored, and

removal. The head and shoulders should be well elevated, and the face inclined towards the opposite side. Very few persons, whatever may be their courage or fortitude, can bear the shock and fatigue of an undertaking of such magnitude in the sitting posture. This precaution is the more necessary if chloroform be given, as I always do in such cases. I am aware that objections have been urged against the administration of this remedy in operations on the mouth, but without, I believe, any just reason. Be this as it may, I have employed this agent, ever since its introduction into practice, in all the amputations, both of the upper and lower jaw, that have fallen under my observation, and I have certainly, thus far, had no cause to regret it. The mouth can always be easily cleared of blood, even if the patient is unconscious, with the finger, or a sponge-mop.

I have never found it necessary, in any of my operations on the upper jaw, to secure the carotid artery, as a means of preventing hemorrhage. Indeed, it is surprising that such a procedure should ever have been recommended, much less practised, by any one. My experience is that there are no structures in the body, of the same extent, in their natural and diseased condition, the removal of which is attended with so little hemorrhage. No skilful surgeon now even employs compression of the carotid artery in these operations, and, as to tying that vessel as a means of security against loss of blood, nothing, it seems to me, could be more absurd and unnecessary. The chief danger from hemorrhage is in the subcutaneous arteries, especially the facial and its branches, and these are always readily controlled by the ligature. The deep-seated arteries, involved in tumors of the upper jaw, seldom bleed much, if care be taken to keep beyond the limits of the diseased tissues. If this precaution be neglected, the hemorrhage may be copious, if not exhausting. The oozing which takes place from the osseous surface, after the exsection is completed, generally speedily ceases of its own accord from the contact merely of the air; when it does not, it is usually easily arrested by compresses wet with a saturated solution of sub-sulphate of iron. The actual cautery can only be required when the vessel is inaccessible to the ligature, or when a portion of the disease has unfortunately been left behind.

In operations upon the upper jaw, unattended with loss of the alveolar and palatine processes, the escape of blood into the throat may generally be effectually prevented by previous plugging of the posterior nares.

The direction, extent, and number of the incisions through the soft parts must necessarily vary with the situation and volume of the tumor. In all these respects, much must be left, in every case, to the judgment and experience of the operator. When the morbid growth is comparatively limited, and seated upon the anterior, or antero-lateral, aspect of the jaw, we shall generally be able to dispense with external incisions altogether, as the object may readily be accomplished simply by dissecting off the lip from its attachments to the bone, and holding it out of the way with a finger or blunt hook. The surface of the tumor having thus been thoroughly denuded, the bone is attacked with the pliers, and severed fairly beyond the line of the disease. By this procedure, which is admirably adapted to the more simple forms of morbid growths, the operation is divested of much of its severity, and not followed by any deformity of the features, save what results from the caving in of the integument.

When the tumor involves the body of the jaw, and is of considerable bulk, the plan which I usually adopt, is to make one long, curvilinear incision, extending across the most prominent part of the tumor, from the commissure of the lips towards the zygomatic process of the malar bone, terminating within a few lines, half an inch, or an inch, of the external angle of the eye, according to the exigencies of the case. In this manner are formed two flaps, the upper of which is convex, and the lower concave, which are then carefully dissected up by bold and rapid strokes of the knife, and held out of the way by trustworthy assistants, who, at the same time, take care to compress the bleeding vessels. The space which this procedure affords is, in general, quite sufficient for the easy removal of the entire tumor, however large or extensive its connections. In my own cases, it has always answered the purpose most thoroughly. Should it, however, be inadequate, it can readily be increased to the requisite extent by carrying the knife horizontally along the inferior border of the orbit, as far over as the nose, as exhibited in fig. 331, from a patient affected with encephaloid disease of the antrum, whom I attended with Professor Pancoast. In making the first of these incisions, the facial artery is neces-

sarily divided, and, in the second, the superior maxillary nerve, together with many of the branches of the portio dura of the seventh pair. In consequence of the injury thus sustained, the parts supplied by these nerves remain a long time paralyzed, although ultimately the face regains, in great degree, its accustomed power and expression.

When the tumor, or enlargement, occupies the anterior and upper portion of the jaw, the external incision may extend vertically upwards by the side of the nose, from the free border of the lip to a level with the orbit of the eye. This will enable the operator to detach the wing of the nose, and to remove, if necessary, the ascending process of the jaw-bone, the lachrymal bone, the inferior turbinated bone, and even the vomer, as I have been compelled to do in several instances.

When the antrum is mainly implicated in the disease, two incisions, representing the form of an inverted T, are necessary, the vertical limb corresponding with the ascending process of the maxillary bone, and the horizontal one with the inferior border of the orbit of the eye. When the tumor is not very large, access may readily be obtained by making a vertical incision through the upper lip, and dissecting away the ala of the nose, as practised by O'Farrall, Syme, and other surgeons; a method which I have myself repeatedly followed with great advantage as it respects the resulting scar.

Whatever may be the form and direction of the incisions, care should be taken that they are sufficiently extensive to afford ready access to the diseased mass. Nothing can be more embarrassing, or display greater defect of judgment in the operator, than a want of room in a case of this kind.

The necessary incisions having been made, and the flaps dissected up, the next step is to remove the tumor. As a preliminary measure, two teeth, one in front and the other behind, must be extracted, to make room for the play of the saw and other instruments. As a general rule, this part of the operation should be performed as soon as the patient is fairly under the influence of chloroform, and, consequently, prior to the division of the soft structures. If done after that, it is liable to occasion delay and annoyance.

The separation of the jaw is generally the work of a few minutes. The limits of the disease being usually well defined, care must be taken to keep on the outside of them, for the twofold purpose of avoiding hemorrhage and removing the whole of the morbid structures. The best contrivance for executing this part of the operation is a pair of pliers. The surgeon should supply himself with at least three of such instruments, of different shapes and sizes, figs. 332, 333, 334, as one is rarely sufficient for the purpose. He should also have several chisels, small saws, a lenticular, and a stout scalpel, the handle of which should terminate in a steel point, that it may be used as a scraper and a cutter, as may be found most expedient.

When it is designed to remove the entire jaw, the saw or pliers should be successively carried through the alveolar process in front, and the horizontal plate behind, close to the middle line, as far back as the corresponding portion of the palate bone, the mucous membrane of the roof of the mouth having been previously divided with the scalpel, to prevent it from being bruised and lacerated. Next, the instrument is to be applied to the malar bone, at or near its junction with the maxillary, and, finally, to the nasal process, which is generally divided on a level with the lower margin of the orbit. The orbital plate of the jaw-bone is commonly left intact, at least in part, as it rarely participates in the morbid action. Should it do so, however, it should be cautiously removed with the chisel and knife, lest the eye and its appendages be injured. All that now remains to be done is to

Fig. 331.

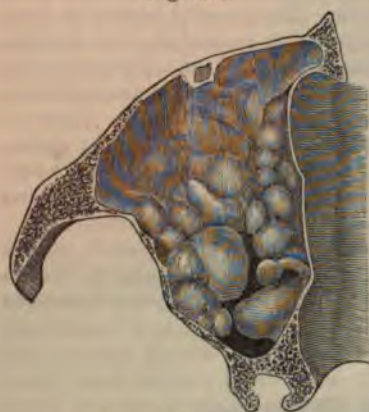


Lines indicating the Course of the Knife in Excision of the Upper Jaw.

shut sac, which contained a yellowish, watery fluid, and was connected with the second molar tooth. Its wall, one-eighth of a line in thickness, was smooth and polished on its internal surface, and was in close contact with, but not attached to, the mucous lining of the chamber.

Cysts of the antrum may be solitary or multiple, their volume, in the latter event, as represented in fig. 328, from Giraldès, ranging from that of a pea to that of a

Fig. 328.



Cysts of the Antrum.

pigeon's egg. Their contents are of a sero-albuminous character, of a whitish, pale-yellowish, or brownish color, and of a thin, watery, or glairy consistence, not unfrequently intermingled with flakes of fibrin, epithelial debris, blood corpuscles, and crystals of cholesterine. Sometimes the cyst suppurates, and thus gives rise to an abscess, attended with great pain and excessive constitutional disturbance. In cases of long standing, the cyst wall is occasionally very much thickened, and rugose on the surface, or even calcified, as in an instance of the dentigerous form of the affection referred to by Mr. Heath and Mr. Salter.

These growths are capable of acquiring a large bulk, expanding the walls of the antrum in every direction, and thus causing the most hideous deformity of the corresponding side of the face. The cheek bulges out like an immense protuberance, the nose is thrown out of shape, the eye protrudes from its socket, the nostril is com-

pletely occluded, and there is a great depression of the palate, along with excessive embarrassment in mastication, articulation, and even deglutition. Their most important diagnostic signs are, their slow, painless development, their crackling feel, or the fact that they are soft at some points and hard at others, the absence of any tendency to ulceration and enlargement of the neighboring lymphatic glands, and the excellence of the general health. When doubt exists a resort to the exploring needle may clear it up. The affection is occasionally witnessed in young subjects, but is most frequent in middle age.

The cystic tumor of the alveolar process is much more frequent than that of the antrum, its usual situation being, according to personal observations, the internal and inferior extremity of the canine fossa, where it may attain the volume of a hen's egg, or even of a small orange. It is usually single, although there may be several sacs, either closely connected together, or separated by osseous septa. The anterior wall of the tumor is composed of a thin, elastic, crackling, parchment-like shell, and is easily penetrated by a sharp instrument, the puncture giving vent to its contents, which are serous, sanguinolent, or of a glairy, mucilaginous nature. This, in fact, is the best diagnostic sign of the morbid growth. The disease is always tardy in its progress, and manifests no disposition to extend among the adjacent structures. In 1860, an old man, a patient of Dr. Piper, was brought to my clinic at the Jefferson Medical College, on account of a cystic tumor situated in the areolar tissue, immediately above the lateral incisor and cuspid teeth. It was about the volume of a lime, and distinctly fluctuated under pressure, its anterior wall crackling like parchment. Its contents were of a serous character. The tumor being opened with a stout knife, its secreting surface was freely touched with chromic acid, a tent being afterwards introduced to keep up the irritation. Healthy granulations soon sprung up, and in less than two months the cavity was completely obliterated.

The treatment of these cystic growths is easily comprehended. In the more simple forms, as in the case just mentioned, the object is readily attained by opening the sac fully, and exciting oblitative action by means of tents and stimulating injections. When the antrum is affected, the management of the case is based upon the same principles as that of abscess, evacuation of the contents of the chamber being effected at the most dependent portion of the tumor. The palate bulging, the opening is made there; or a decayed tooth is extracted, and the fluid is allowed to drain off along the resulting channel, widened, if necessary, by artificial means. Gradually the osseous cyst contracts, and, reaccumulation being prevented, it is eventually obliterated, the process being often advantageously expedited by the use of mildly

astringent injections. If the cure be very tardy, in consequence of the great bulk of the tumor, or the presence of an imbedded tooth, or multiple cysts, it will be well to cut away a portion of its outer wall and remove the offending substance, care being taken not to injure the integument of the face. When the tumor is of large size and of long standing, thorough extirpation alone will be likely to afford relief.

β. *Polyps*.—It is rare to meet with polyps of the maxillary sinus. A great variety of morbid growths, having scarcely any points of resemblance, have been described under this name, much to the detriment of sound pathology and practice. The term, however, should be restricted to those gelatinoid or vesicular growths which, being developed from the mucous membrane, are closely allied to cystic tumors, and are similar to soft polyps of the nose. Luschka met with these formations five times in sixty autopsies, and Förster, Billroth, and Virchow have delineated striking examples of the affection.

Polyps of the antrum rarely acquire large dimensions, and, therefore, seldom call for surgical interference. They have, however, been observed to attain considerable bulk, when they either protrude into the nasal cavities or expand the walls of the sinus. Under these circumstances, the symptoms and treatment do not differ from those of cystic disease.

γ. *Vascular Tumors*.—A tumor, having all the properties of an anastomotic aneurism, is occasionally developed in the maxillary sinus. It is difficult to determine whether it takes its rise in the mucous membrane of the sinus, or in its bony walls. However this may be, it appears to consist essentially in an enlargement of the branches of the internal maxillary artery, which interlace with each other in every conceivable manner, and thus form a tumor of an erectile character, similar to *nævus* of the face. As the affection progresses, the walls of the antrum are absorbed, and the morbid growth is thus placed immediately beneath the skin, feeling like a soft, spongy mass, and exhibiting a bluish, purple, or modena color. Its pulsation, which is synchronous with the contraction of the left ventricle, is very distinct under the finger, and may generally be seen at some distance. When the tumor is very large, it encroaches upon the eye, nose, and mouth, and is productive of great deformity.

The prominent symptoms of the disease are, its steady increase, its tendency to encroach upon the surrounding parts, its soft, spongy consistence, its pulsatile movements, and the livid discoloration of its surface, both external and internal. The attendant pain is usually slight, and the general health is seldom impaired, until after the establishment of nasal hemorrhage, which is sure to set in sooner or later, and which is often profuse and draining in its effects.

If the tumor be seen early, or, rather, if it be recognized before it has attained any considerable bulk, the proper procedure would be to expose it by a careful dissection, and effect its destruction with the actual cautery, the Vienna paste, or acid nitrate of mercury. Perhaps a portion of the growth might be constricted with the ligature, as in the operation for the radical cure of hemorrhoids. When it has attained a large size, ligation of the common carotid artery, as proposed and practised by the late Professor Granville S. Pattison, may be tried, although, it must be confessed, with but a faint prospect of success.

δ. *Fibrous Tumors*.—Pure fibrous tumors of the upper jaw are not very common, but, in connection with the lower maxilla, they constitute the larger proportion of all fibromas of the osseous system. Taking their origin in the soft layer of the periosteum or the lining membrane of the Haversian canals, they usually spring from the facial surface or the alveolar border of the bone, in the latter of which they constitute fibrous epulis. They are also developed in the antrum, either as pyriform or polypoid outgrowths, or, as more frequently happens, as lobulated tumors, which evince a great disposition to expand its walls in every direction, project into the nose, protrude the eye, cheek, and hard palate, and, finally, perforate or disintegrate the bone, which is ultimately lost in the new product.

The fibrous tumor of the upper maxilla almost always contains small masses of hyaline cartilage and spicules of bone, the latter element often being so predominant as to entitle it to be called osteoid fibroma. The osseous proliferation of the periosteum, indeed, may invade the fibrous tissue to such an extent as to convert the growth into an osteoma, and many exostoses, doubtless, arise in this way. On the other hand, but very seldom, numerous cartilaginous nodules are interspersed through the mass, giving rise to lobulated tumors, which are appropriately termed enchondromatous fibromas. In addition to these transformations, cysts or cavities, con-

inflammation progresses, the periosteum is detached at the most highly inflamed part, which is usually around the extremity of the fang, and the sac thus formed becomes the receptacle of the pus. The denuded portion of the tooth loses its vitality, thereby adding to the irritation of the socket, which, in consequence, takes on ulcerative action, followed by a fistulous opening, and the escape of the accumulated fluid, beneath the gum, thus constituting what is called a gum-boil, parulis, or alveolar abscess. If the tooth be extracted after this occurrence, the sac will often come away in the form of a red, fungous mass, not unlike a small polyp. Fig. 358 and fig. 359 afford excellent illustrations of different forms of the sac in alveolar abscess.

Fig. 358.

Fig. 359.



Different Forms of the Sac in Alveolar Abscess.

Dental periostitis sometimes occurs as an independent affection, but in most cases it is caused by the irritation of a decayed tooth, or by external violence. However induced, the pain is usually excessive, pulsatile, and accompanied with great swelling of the surrounding parts, especially of the face. Severe constitutional disturbance often attends, especially when matter is about to form. The fluid always points on the outside of the gum, as if nature were averse to making an opening in any other part of the alveolar process. To this rule, however, there is occasionally an important exception, the matter finding a vent at the roof of the mouth or at the posterior naris. Such an occurrence, which is always attended with great and protracted suffering, will be most likely to happen when the abscess has been occasioned by a number of diseased teeth.

The treatment is strictly antiphlogistic; by leeches and purgatives, followed by anodynes, diaphoretics, fomentations, and poultices. The leeches may be applied directly to the inflamed gum. If matter forms, it must be promptly evacuated, otherwise it will not only keep up the pain, but may cause extensive destruction of the periosteum and bone.

10. Dental Fistule.—A dental fistule is always the result of a gum-boil, and often proves a source of much annoyance, as it is invariably connected with disease of an adjoining tooth and necrosis of the wall of its socket. The passage is generally short and narrow, frequently hardly admitting the finest probe. The orifice leading to it is usually indicated by a little reddish papilla, emitting, on pressure, a small drop of pus; in some cases it is temporarily closed, but reopens whenever there is an increase of matter. The most effectual remedy for this affection is the prompt removal of the offending tooth; this, however, is not always absolutely necessary, as the disease upon which the fistule depends occasionally disappears spontaneously, or under very simple treatment, especially a free incision and the use of astringent washes.

A dental fistule, instead of communicating with the mouth, occasionally opens upon the cheek, causing troublesome swelling and irritation, along with more or less discharge and disfigurement. The true nature of the affection may generally be readily determined by the use of the probe and by a careful inspection of the teeth, one or more of which will always be found to be diseased. A passage of this description is sometimes very large and devious. Its most common situation is at the base of the jaw, but it is occasionally met with on the cheek, in consequence of necrosis of the upper maxillary bone. Should the passage not close after the removal of the diseased structures, its edges should be freely excised, and then carefully approximated by suture, as in the common harelip operation.

11. Serous Cysts.—Cysts, of varying size and shape, form in connection with the fangs of the teeth, and eventually give rise to serious disorders of the jaw. Dupuytren, who was the first to notice these affections, states that they are most frequently met with in the sockets of the upper canines, but they are found in all situations, and it is now well ascertained that the large teeth are more liable to them than the small. The sac is always closely attached to the root of the tooth, often by a long, narrow pedicle, and generally comes away along with it when the tooth is extracted, especially when the operation is performed before the cyst has attained any considerable bulk. The cyst-wall consists of a single layer with a smooth internal surface, and the contents are either serous, or of a thick, glairy character. The cyst has, in rare cases, been observed to be calcified, but it is more

frequently converted into an abscess from caries of the root of the tooth to which it is attached. In a remarkable instance of this nature, in a patient, twenty-five years of age, recorded by Professor Weber, of Heidelberg, the cyst sprung from the last molar tooth, and had, in twelve months, expanded the lower jaw into a tumor which extended to the mental foramen, and contained three ounces of thick matter, rich in fat and cholesterine. Now and then the pus corpuscles wither and undergo the fatty degeneration, converting the sac into a semisolid tumor, as in a case reported by Dr. Chase, of Iowa City. On extracting a decayed first upper molar tooth, he brought away with it a large portion of the alveolar substance, the bicuspid fang, and a cyst, fig. 360, which had extended into the antrum. Its contents were of a light yellowish color, tinged, here and there, with red, and of the consistence of soft cheese. When the cyst is left behind in the extraction of the affected tooth, it inflames and suppurates, causing much local and constitutional distress. The morbid growth is not attended by any diagnostic signs. The treatment consists in removing the loosened tooth, and digging out the cyst, if it be not detached during the extraction.

Fig. 360.



Purulent Cyst of a Molar Tooth.

12. *Osseous Tumors*.—The teeth, especially the grinders, are liable to osteomas, which, springing from the neck or fangs, occur either in the form of ordinary exostosis, fig. 361, from Forget and Heath, composed of cement and developed from the periodontal membrane, or of ivory exostosis—the odontoma of Virchow—which is made up of hypertrophied dentine, and originates in the pulp. In the latter variety of the affection the crown of a single tooth, or of two teeth blended together, is the usual seat of the affection, being converted into an irregular, confused, shapeless mass, termed “warty” by Mr. Salter. The diffused form of odontoma, or the condition in which the entire tooth is involved, is of particular interest to the surgeon, as it gives rise to considerable tumors of the jaws, which may be symmetrical, as in the case of Oudet, in which the swelling was due to fusion of the lower canine and incisor teeth. In the remaining examples, five in number, described by Wedl, Forget, Tomes, Billroth, and Harrison, the tumor was confined to one side of the inferior maxilla, with the exception of that of Billroth in which the second upper molar tooth was affected. The most remarkable of these tumors is that in which Forget removed the molar portion and angle of the jaw of a man, twenty years of age, for a mass, representing two grinders, of the volume of a turkey’s egg. The growth first appeared at the age of five years, and was the seat of occasional pain and of a purulent discharge from sinuses extending from the external surface to its base. The submaxillary lymphatic glands were enlarged.

Fig. 361.



Osteoma of a Molar Tooth.

The symptoms of dental osteomas are too obscure to be of any diagnostic value. The pressure of the tumor upon the surrounding parts must necessarily cause more or less pain, which, however, it is impossible to distinguish from that of ordinary toothache. The only remedy is extraction of the offending organ or excision of the jaw, as in the case just mentioned, when the tumor has acquired large bulk.

13. *Formation and Accumulation of Tartar*.—The teeth, from want of cleanliness, as well as other causes, are very prone to become affected with earthy deposits. Originally, the substance possesses the character of a soft, friable, porous paste, which by degrees acquires the consistence of hardened mortar, and then often scales off in large masses, having the shape of the organ around which it was formed. Its usual color is a dull whitish yellow, although in some cases it is dark brown, blackish, or slightly greenish. It is principally composed of phosphate of lime, in association with mucus and a small quantity of animal and fatty matter.

The accumulation of this substance, vulgarly called tartar, often takes place with great rapidity, so that in a short time the dental arches are almost completely incrustated with it. Calculous, gouty, and dyspeptic persons are particularly liable

to it; and it is also frequently witnessed during pregnancy and lactation. The deposit ordinarily begins around the necks of the teeth, just beneath the free margin of the gum. As it increases in quantity, it produces the most disastrous effects, exciting irritation in the soft parts, which, in its turn, leads to absorption of the gum and alveolar processes, until the teeth, deprived of their support, are loosened, and at length drop out.

It has been supposed that this matter is derived directly from the mucous secretions of the mouth, vitiated by chronic irritation; but the more plausible opinion is that it is exclusively furnished by the salivary glands, being held in solution by the fluid which it is the office of these organs to elaborate. This view of the subject is not only supported by the analogy which obtains in the formation of urinary calculi, but by the fact that this substance is always most abundantly deposited upon the superior grinders and the inferior incisors, teeth which lie in the immediate vicinity of the orifices of the salivary ducts; and also by the circumstance that it is composed of the same elements as the salivary secretion.

The treatment of tartar consists in its early removal by means of a brush and soft powder; or, if this is inadequate, by a suitable scaling instrument. If the matter is very firmly adherent, the operation must be performed with great care, otherwise there will be danger of loosening the teeth, as the point of the instrument is carried around their necks, between the gum and the concretion. Reaccumulation is prevented by diligent attention to cleanliness and to the general health.

14. *Toothache*.—This affection, technically known as odontalgia, is usually caused by caries of the teeth, leading to exposure of the nerve-pulp to the air, to the juices of the mouth, and to various kinds of extraneous matter. It may also be caused by inflammation and thickening of the dental periosteum, by necrosis of the teeth, exostosis, external injury, profuse salivation, and various morbid affections of the gums and jaws. There is a form of odontalgia which occurs in gouty, rheumatic subjects, apparently unconnected with any organic lesion whatever of the teeth. Occasionally, again, the disease is of a neuralgic character, coming on in violent paroxysms, which, however, seldom observe any regularity in regard to the period of their recurrence.

However induced, odontalgia is generally characterized by atrocious pains, of a throbbing, jumping nature, deep-seated, and, although most severe at the seat of the disease, darting with great violence along the branches of the fifth pair of nerves distributed to the affected jaw. In some cases, the pain is dull, aching, or gnawing. It is always aggravated by exposure to cold, by disorder of the general health, by cold and hot drinks, by acid, alkaline, and saccharine matter, and by recumbency. Hence, it is almost always worse at night after the patient retires to his bed, the throbbing commencing the moment the head touches the pillow. In the more severe forms of odontalgia, the pain extends to the ear along the nervous cord of the tympanum; and there is generally great soreness of the face, temple, and even the corresponding side of the head. Children, pregnant women, and dyspeptic persons are extremely prone to suffer from toothache from the most trifling circumstances.

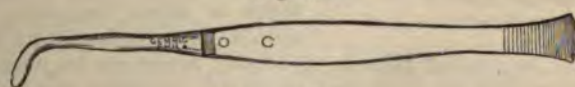
The treatment of odontalgia must depend very much upon the nature of its exciting causes. When it has been induced by caries, and the decay has advanced so far as to render the preservation of the tooth a matter of impossibility, the only proper remedy is immediate extraction, before there is any serious inflammation of the gum and jaw. The same course is pursued when a tooth is necrosed, or the seat of exostosis; when there is chronic thickening of the dental periosteum, with the repeated formation of abscesses; or, finally, when the affected organ has measurably lost its connection with the alveolar process, whether from disease in the organ itself, or in the jaw. If, on the contrary, the decay is comparatively trifling, an attempt should be made to retain the tooth, and with this view the cavity should be gently filled with cotton, wet with a strong solution of morphia, aconite, and tannic acid, which often arrests the pain in a few minutes. If the suffering is very severe, the patient should at once take an active cathartic, especially when there is considerable derangement of the general health. The medicine may be followed, if necessary, by a full anodyne and diaphoretic. Should there be much swelling of the gums, a few leeches may be applied, or, if these cannot be had, the parts may be freely divided with the knife. Pain in the ear is best relieved by laudanum, and of the face by a hop poultice, or, what is better, an ammoniated liniment, strongly charged with

morphia and tincture of aconite. When the pain is dependent upon malarious influences, quinine and arsenic will be proper; if upon a gouty or rheumatic diathesis, relief will probably be afforded by colchicum. If matter form, it must speedily be evacuated. The offending tooth should not be extracted so long as there is violent inflammation. If the organ can be saved, it should be plugged as soon as it can bear the necessary manipulation. Of the numerous domestic remedies for odontalgia, there is not a solitary one deserving of any attention; most of them, in fact, are much more hurtful than beneficial.

15. *Extraction of Teeth.*—Extraction of the teeth may become necessary for various reasons, but more especially for the relief of pain consequent upon caries and necrosis of these organs, and on account of the irregularity of their position. In children, the operation is often required to make way for the permanent teeth. The deciduous teeth are always easy of extraction, owing to the partial absorption of their roots; the permanent, on the contrary, often demand great skill for their successful removal, especially when they are much decayed, when they are unusually brittle, or when their fangs are very firmly adherent, or widely separated. In the former case, they will be very apt to break off, while, in the latter, it is sometimes impossible to dislodge them without fracturing the alveolar process. There is generally a great prejudice, even on the part of dentists, against the extraction of the deciduous teeth, on the supposition that it has a tendency to interfere with the development of the permanent set. I have been at much pains to inquire into this matter, and am satisfied that the idea is altogether erroneous; on the contrary, the operation, so far from being injurious, will generally be found to be eminently beneficial, not only relieving pain, but conducing to the beauty and perfection of the future organs.

The patient, during the operation, sits upon a chair or a low stool, as may be most convenient; if the surgeon stands behind, he himself, of course, supports the head, otherwise this function is performed by an assistant. The office of the dentist is always furnished with a high-backed chair, for the accommodation of the head. The safest anæsthetic, undoubtedly, is nitrous oxide gas, which has now been administered in many thousand cases without a single accident. If chloroform be given, the patient must be partially recumbent, and it will be well not to carry the effect of the remedy to complete unconsciousness, lest harm should result. Ether is, on the whole, more safe than chloroform, and should, therefore, be preferred, especially as its use does not require recumbency, or much caution of any kind. If the patient is an adult, it will be proper, as a preliminary measure, to separate the gum from the affected tooth, down to the very neck of the organ, with the twofold object of preventing laceration of the soft parts, and of facilitating the extraction; but in

Fig. 362.



Gum Lancet.

the child, no such precaution is ever required, as the connection between these structures is much less intimate than in the adult. The operation is readily performed with a gum-lancet, fig. 362. A medium-sized cork attached to a piece of twine is interposed between the grinders to keep the jaws apart during the operation.

The instruments required for the extraction of the teeth are the forceps, key, elevator, and hook, the latter two being particularly useful in the removal of stumps, and of loose, deciduous teeth.

1. *Forceps.*—The forceps should be provided with short, stout blades, variously shaped, with a view to their easy adaptation to the different classes of teeth, as well as the same classes in the two jaws, and be rather sharp at the edges, that they may be readily pressed down between the gum and the tooth, in close contact with the border of the alveolar process. The instrument should be large in the handle, so as to afford a firm grasp for the hand. The annexed cuts, figs. 363, 364, 365, 366, and 367, represent the different forms of forceps usually found in the dentist's case; but the ordinary operator will rarely require more than two, one straight, for the incisors and cuspids, the other curved, for the bicuspid and grinders.

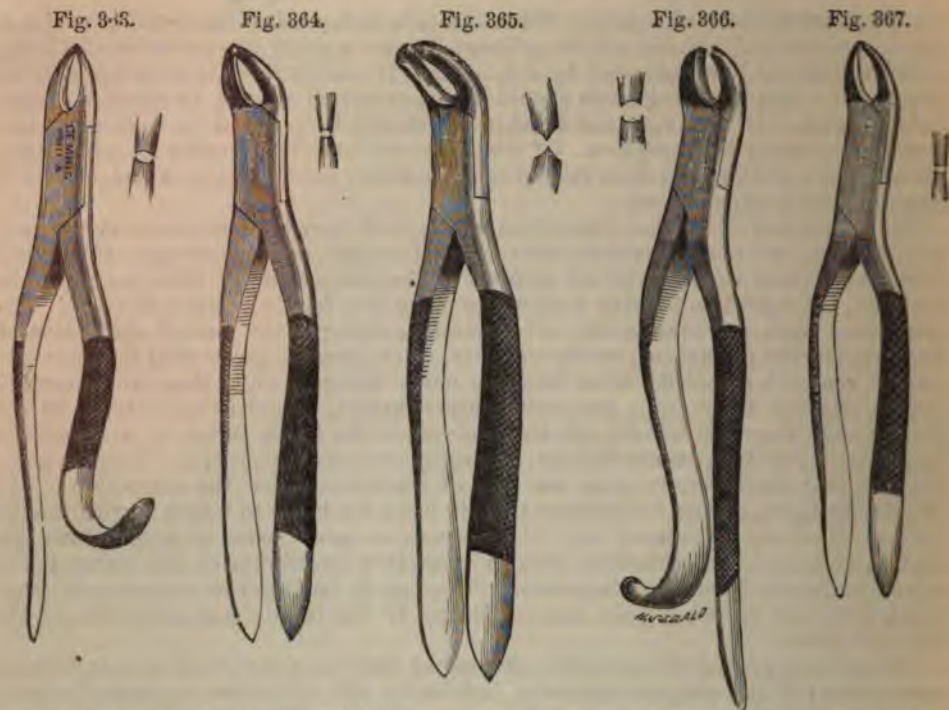


Fig. 363, Front Incisor Forcep. Fig. 364, Lower Bicuspid Forcep. Fig. 365, Lower Molar Forcep, Right and Left. Fig. 366, Upper Molar Forcep. Fig. 367, Universal Root Forcep.

The incisors, cuspids, and bicuspid are extracted on the principle of rotation and traction, the first movement being intended to separate the tooth from its connections, the second to lift it from its socket. Usually more force is required for the

Fig. 368.



Mode of Seizing a Tooth.

removal of the cuspids and bicuspid than for the dislodgment of the incisors. The rule is to apply the blades of the forceps as near as possible to the neck of the tooth, as seen in fig. 368. This procedure, which should not be deviated from in any case, is particularly necessary when the tooth is much decayed. The instrument should be held firmly in the hand, but no

more force should be applied than is absolutely necessary to prevent it from slipping. If this precaution be neglected, there will be great danger of crushing the tooth, and so complicating the operation. In extracting a bicuspid, the organ should be loosened by pressing it several times outwards and inwards, as it is, in great measure, insusceptible of rotatory motion; as soon as it begins to yield, dislodgment is effected by elevating or depressing the hand, according as the tooth is a lower or an upper one.

Extraction of the molar teeth or grinders is effected on the same principle as that of the bicuspid; that is, the forceps are applied very firmly to the neck of the organ, which is then pressed several times outwards and inwards, until it feels decidedly loose, when it may readily be disengaged from its socket. The wisdom teeth, owing to the shortness of their roots, are always easily removed, comparatively little lateral motion and traction sufficing for the purpose. The most suitable instrument for the extraction of the lower wisdom teeth is the scissor-bladed forceps, now generally used by dentists.

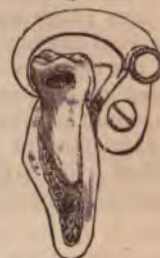
2. *Key*.—The key is seldom employed for the extraction of teeth; it is an awkward, clumsy instrument, and often does great mischief, bruising and lacerating the gum, splintering the alveolar process, and inflicting severe pain. Moreover, unless particular care be taken in its application, the operation is very liable to be

attended with fracture of the body of the tooth, leaving the fangs in their sockets, from which it will afterwards be extremely difficult, if not impossible, to dislodge them. The forceps, therefore, always deserve a decided preference. Nevertheless, there are circumstances which may render a resort to the key very proper, if not absolutely indispensable; especially when the teeth are unusually large, or very firmly imbedded in the jaw, and the operator does not possess the requisite strength for the efficient use of the forceps.

The application of the key is conducted upon the same general principles as that of the forceps. The gum being well separated, the point of the instrument is pressed down between it and the neck of the tooth, which is then lifted perpendicularly, or nearly so, from its sockets, the whole procedure consisting in a forcible dislocation of the organ. If the key is too long, or applied too high up, it will almost inevitably break off the crown, or fracture the jaw. The proper position of the instrument is exhibited in fig. 369. To guard against mishaps, the surgeon should be provided with several keys, of different shapes and sizes, so as to adapt them to the exigencies of each particular case. In operating upon the inferior bicuspid and the upper grinders, the fulcrum is applied to the inner surface of the jaw, and to the outer in operating upon the lower grinders, the wisdom teeth being always removed with the forceps.

3. *Elevator and Hook.*—The elevator, represented in fig. 370, was formerly much employed for the removal of stumps and fangs, but has been entirely superseded in

Fig. 369.



Application of the Key.

Fig. 370.



Elevator.

Fig. 371.



Hook.

the hands of the scientific dentist by the root-forceps, represented in fig. 367. In using the elevator great care is necessary, otherwise the instrument might slip, and so inflict severe injury upon the mouth. Such an accident is best avoided by firmly steadying the patient's head, and planting the point of the instrument securely against the projecting portion of the tooth, which is then forcibly raised from its socket.

For the removal of small fangs, or fangs that are deeply buried in the jaw, the most suitable instrument, perhaps, is the one depicted in fig. 371. In order to facilitate dislodgment in this condition, it is sometimes necessary to cut away a small portion of the alveolar process, an operation which is easily done with a stout, narrow scalpel.

4. *Hemorrhage after Extraction.*—It is very unusual for extraction of the teeth to be followed by hemorrhage, the loss of blood rarely exceeding a few drachms. Occasionally, however, owing to idiosyncrasy, or to an unnatural disposition of the dental artery, the bleeding is both troublesome and profuse, causing, perhaps, great anxiety for the patient's safety. I have myself seen several instances of this kind, and am familiar with the history of two in which the loss of blood terminated fatally. The hemorrhage occurs at various periods after the operation; sometimes immediately, at other times not until after the lapse of several hours, or, it may be, even several days. The blood may issue from one particular vessel, or ooze from numerous points; the latter form being the more common when the patient is laboring under the hemorrhagic diathesis.

The treatment consists in the prompt reinsertion of the removed tooth, or, if this be impracticable, in plugging the affected socket with a piece of soft sponge, wet with a saturated solution of alum and tannic acid, or, what is better, subsulphate of iron, the cavity being previously well dried. The sponge is confined by a thick, narrow compress, and the jaws are firmly closed by a roller passed around the head. If this be insufficient, the socket should be filled with plaster of Paris, or white wax, properly softened, and firmly pressed into the bleeding cavity. The patient is kept in

the semierect posture in bed, and a full anodyne is administered to allay the heart's action. The diet and drink must be cooling. If the hemorrhagic diathesis exist, recourse must be had to the exhibition of tannate of iron, or acetate of lead and opium, with a view of promoting the coagulation of the blood. In obstinate cases, or where plugging is impracticable, on account of fracture of the alveolar process, the actual cautery may be necessary.

In the eighth volume of the Medico-Chirurgical Transactions of London, are the particulars of a case in which Sir Benjamin Brodie tied the common carotid artery, on account of hemorrhage from the second branch of the internal maxillary, after the extraction of the second molar tooth of the upper jaw. The patient, however, perished from a general oozing of blood from the part, after the bleeding had been temporarily checked by the operation.

SECT. IV.—AFFECTIONS OF THE GUMS.

The gums are liable to various accidents and diseases, of which the most important are wounds or lacerations, inflammation, ulceration, gangrene, scorbutic enlargement, tumors, and malignant disease. They are also occasionally the seat of congenital hypertrophy.

1. *Wounds*.—Wounds and lacerations of the gums are usually the result of falls or blows, fracturing the jaws, or of the extraction of the teeth, and should be managed upon the same general principles as similar lesions in other parts of the body. A good deal of bleeding sometimes attends them, which, however, either ceases spontaneously or is easily arrested by astringent lotions, especially strong solutions of alum and tannic acid, or, what is still better, subsulphate of iron.

2. *Inflammation*.—Inflammation of the gums may be caused in various ways, as an accumulation of tartar around the teeth, disorder of the digestive apparatus, a depraved state of the blood, and the effects of mercury and phosphorus. The symptoms are discoloration, with a soft and spongy state of the affected structures, more or less pain, and an increase of the mucous and salivary secretions. When the disease is severe or protracted, the teeth are apt to become loose, and the patient finds it difficult to masticate.

The treatment must be regulated by the nature of the exciting cause. Calculous deposits must be removed, the condition of the digestive organs rectified, and the general health improved. The milder cases will often get well spontaneously, or under the influence of a brisk cathartic and the use of an astringent mouth-wash. When the inflammation has been occasioned by mercury, the most appropriate remedies are purgatives, strong lotions of acetate of lead, and the liberal exhibition of chlorate of potassa, with leeches and warm poultices to the neck and jaws. In obstinate cases, emetics of ipecacuanha will prove useful.

3. *Ulceration*.—One of the most frequent lesions of the gums is ulceration, produced by an accumulation of tartar around the necks of the teeth. The pressure that is thus exerted excites inflammatory action, leading to great thickening, sponginess, and discoloration of the gum, with erosion of its substance. In this way the teeth are entirely denuded at their necks, in consequence of which they often drop from their sockets, or become so loose as to be useless. The treatment consists in the removal of the offending tartar, and the use of medicated lotions, containing alum, tannic acid, and myrrh. The milder cases will generally rapidly yield under the application of powdered alum.

4. *Mortification*.—The gum, in common with the rest of the buccal mucous membrane, is liable to mortification, from excessive mercurial action, the fumes of phosphorus, and probably also from causes which exert their influence chiefly through the constitution. Of this nature appears to be that variety of mortification which has been so ably described by the old writers under the name of "black canker," and by Dr. B. H. Coates under that of the "gangrenous ulcer" of the mouth. Although it may begin at any part of the mucous membrane, yet, in by far the greater number of cases, it makes its appearance at the edges of the gum, over the neck of the central incisors of the lower jaw, in the form of a whitish, cineritious, or reddish ulcer, varying in diameter from half a line to the eighth of an inch. In this state, the disease may continue for several weeks, if not months; but more commonly it extends its ravages, affecting either a large portion of the dental arches, or passing down in the direction of the sockets of the teeth, which, together with their periosteum and the

alveolar processes, are gradually deprived of their vitality. The soft parts, in the meanwhile, assume a dirty, blackish appearance; and, on being detached, leave a ragged, sloughing ulcer, which is the seat of a foul, sanious discharge, of so excessively acrid a nature as to excoriate whatever texture it may touch. In this manner, the disease appears to be frequently propagated to the mucous membrane of the cheeks and lips, where it generally spreads with great rapidity, until the parts are completely perforated, or a black, gangrenous spot manifests itself upon the external surface.

The true pathology of this disease is still involved in obscurity. It is almost wholly confined in its attacks to young, weakly subjects, and occasionally displays an endemic tendency. Thus, of 240 children observed by Dr. Coates in the Philadelphia Asylum, upwards of 70 were more or less affected with the primary ulcer at one time. In the early stage of the complaint there is little or no pain, the system is free from excitement, and the appetite and strength are scarcely at all impaired. When the sloughing process, however, has fairly commenced, the child suffers much local distress, and is harassed with constant fever. Dissection has thrown no light upon this singular variety of gangrene.

The treatment must be regulated by the nature of the exciting cause. Supporting measures, as quinine, iron, ammonia, and brandy, with a nutritious diet, are indispensable, and do more than anything else to arrest the spread of the disease. The most appropriate local remedies are lotions of acid nitrate of mercury, nitrate of silver, chloride of iron, and sulphate of copper, along with permanganate of potassa, for the purpose of allaying the excessive fetor. If the disease extends to the cheeks, recourse may be had to the topical use of iodine.

5. *Inflammatory Enlargement*.—Enormous enlargement of the gums is sometimes witnessed, especially in scurvy. When thus affected, they are of a red, livid, or purple appearance, and of a soft, spongy consistence, generally bleeding on the slightest touch, and forming two large ridges, in which the teeth, loose and discolored, are, at times, almost completely buried. The enlargement is of an inflammatory nature, and probably depends upon a depraved state of the system, produced by impoverished diet and other depressing influences.

The treatment is constitutional and local. Tonics, as quinine and the mineral acids, and nutritious diet, with brandy, wine, or porter, are generally required. When there is a marked scorbutic state of the system, subacid vegetables and drinks are indicated. The swollen gums should be frequently scarified, or even partially cut away, and touched once a day with a strong solution of nitric acid. In a remarkable case of this disease, under my charge, in 1851, more benefit was obtained from this application than from any other of the numerous articles that were tried, including creasote, copper, iron, myrrh, and alum. The teeth should not be extracted, unless they are hopelessly loose, as they generally regain their hold during convalescence. Any tartar that may incrust them should, of course, be carefully removed.

6. *Hypertrophy*.—Hypertrophy of the gums, eventuating in the formation of a hard, dense, grayish structure, of a fibroid character, is observed chiefly in elderly persons, after the loss of the teeth, apparently from the pressure exerted upon them by the food in eating. In some instances that have been brought under my observation, the growth was manifestly due to the pressure and suction kept up by the plate of an artificial set of teeth. The hypertrophy is generally very gradual in its development, but may eventually acquire a considerable bulk, larger at some points than at others, and occupying, in some cases, the greater portion of the outline of the gums, forming hard, firm masses, projecting from the jaw, and interfering more or less with mastication, although rarely causing any pain. The upper gum suffers more frequently than the inferior.

The only remedy is excision, followed by the application of sulphate of copper, or, what is better, the heated iron, to prevent repullulation. The operation is sometimes followed by secondary hemorrhage, requiring the ligature, or, when the blood oozes from numerous points, Monsel's salt.

Hypertrophy of the gums is sometimes congenital, and is then liable to be attended with more or less deformity of the mouth and lips. The only case of the kind I have ever seen occurred in a lad ten years old, remarkable for his stunted development, ill-shaped head, and large abdomen. The morbid growth affected the gums of both jaws, and was of a dense, fibroid structure. It first began to attract attention at the

age of nine months, but there can be no doubt, from its history, that it had existed from birth.

The gum of the upper jaw formed a tumor of a pale color, inelastic, perfectly insensible, and of firm consistence, presenting very much the appearance of the snout of a hog. It stood off very obliquely, and received but a very partial covering from the corresponding lip. It was rough on the surface, and was about an inch and a quarter in its antero-posterior diameter, its width having been about one inch and a half. At its free margin, which was quite irregular, was seen the tip of the left central incisor. Extending back from this tumor, on each side of the whole length of the jaw, was the enlarged gum, forming a thick, broad ridge, completely imbedding the teeth. At several points, particularly behind, the morbid growth was more than nine lines in width; in front and at the middle it was less. It was of a more florid color than the main tumor, but of about the same degree of consistence. Opposite

Fig. 372.



Hypertrophy of the Gums.

the bicuspid teeth, on each side, it exhibited a remarkably granulated appearance, the excrescences having a pedunculated form, and being folded upon each other. Projecting towards the roof of the mouth, it greatly encroached upon this cavity, lessening its capacity, and thus interfering with its functions, as well as with speech and respiration.

The lower gum was in the same condition as the upper, being equally hard and insensible, but less developed. It was of a bluish, florid complexion, and larger in front and behind than at the intermediate points; its free surface was uneven, and so prominent as to hide all the teeth, except the central incisors, the point of the right cuspid, and the cusps of each deciduous and first permanent molars. This singular formation is well shown in the accompanying cut, fig. 372. The treatment consisted of thorough removal, by means of scalpels and scaling instruments. A good deal of blood was lost, and the operation, which had to be several times repeated, was necessarily tedious. Dr. J. N. M. Lynch, of Kentucky, who was

kind enough to bring this patient to me in 1855, informed me, four years afterwards, that the gums had again commenced to grow, and that there was marked disease of the heart, with considerable enlargement of the tonsils, the arches of the palate, and the papillæ of the tongue.

Remarkable cases of hypertrophy of the gums have been recorded by Pollock, Heath, MacGillivray, and Waterman. The latter refers to one in which the disease was associated with feeble intellect and an extraordinary hairy growth; and, in that observed by Pollock, the patient was subject to epilepsy, and had also an unusual pilous development. My own patient was a stunted and feeble-minded boy. A curious example of partial hypertrophy of the gums, occurring during several pregnancies, has been related by Dr. J. Pitcairn.

7. *Cystic Tumor*.—Tumors, simple or multiple—more usually the former—containing a whitish, glairy, turbid, or chocolate-colored fluid, are sometimes, although rarely, met with in the gums, or at the side of the gums, behind the mucous membrane where it is reflected from the alveolar border to the cheek. Like similar tumors in other situations, they are of slow development, but are capable of attaining a considerable bulk. They are painless, fluctuate more or less on pressure, and eventually interfere with mastication and articulation. Their pressure is sometimes so great as to occasion partial absorption of the jaw-bone. The exciting cause is generally external injury, or disease of a contiguous tooth. The most important diagnostic signs are the history of the case, the absence of pain, and the presence of fluctuation. The best remedy is excision, or, when this is difficult, laying the cyst freely open, and mopping the surface well with tincture of iodine, to excite obliterative inflammation.

8. *Fibroid Tumor*.—Epulis, described in a former page, is a growth altogether different from that which occasionally springs from the interdental gum, or the gum between two contiguous teeth. It is usually small, of a polypoid shape, of a pale-reddish color, of a dense, firm, fibrous structure, insensible, and indisposed to

ulcerate, although sometimes it bleeds a good deal, especially when it is unusually vascular. The most common exciting cause is the irritation of a carious tooth, the cavity of which it occasionally completely fills, and it may even project considerably above the surrounding level.

Removal is effected with the knife, repullulation being prevented with tannic acid, nitrate of silver, and similar means. The teeth which are the cause of the morbid growth generally require extraction.

9. *Papillary Tumor*.—Under the appellation of “wart-like tumor of the gum,” Mr. Salter has described a morbid growth, which, after removal, recurred several times, and which seems to have been essentially a connective-tissue tumor, with hyperplasia of the papillæ of the mucous membrane, not unlike what is occasionally met with upon the tongue and hard palate. The acuminate papillæ were soft, upwards of half an inch in length, and composed almost entirely of epithelium. The annexed sketch, fig. 373, from Heath, conveys a better idea of the appearances of this rare growth than any description, however elaborate. Excision is the proper remedy.

Fig. 373.



Papilloma of the Gum.

10. *Vascular Tumor*.—A tumor, resembling a nævus in appearance, and also somewhat in structure, is liable to form on the gum, more particularly along the front teeth, looking, at first, as Mr. Tomes has correctly observed, like a bright-red pimple, slightly elevated above the surface, and gradually increasing until it attains the bulk of a pea, cherry, or almond. It is generally attached by a rather narrow pedicle, bleeds freely when rudely touched, and is of a soft, spongy consistence, being composed essentially of fibro-cellular tissue, pervaded by blood-vessels. Like other growths of the gum, it ultimately separates and even dislodges the teeth, and thus becomes a source of serious suffering, especially by the frequency of the recurring hemorrhage. The only effectual remedies are the knife and the actual cautery.

10. *Epithelioma*.—The gums are liable to carcinoma, generally of a secondary character, from extension of the disease from the lower lip and jaw. I have now under my care a man, fifty years of age, in whom it began in the sublingual glands. Occasionally, however, it originates in the gum itself. In what is called carcinomatous epulis, described in a preceding page, the morbid action probably always, or nearly always, takes its rise in the gingival glands.

Epithelioma of the gum exhibits the same characters, symptoms, and progress as carcinoma of the lip, tongue, and cheek. The pain is of a sharp, pungent, lancinating character, the discharge excessively fetid, and the surface tuberculated, with a tendency to hemorrhage, especially in the more advanced stages of the disease. The neighboring parts are gradually involved, the lymphatic glands become enlarged, the general health is undermined, and the patient finally dies in a state of excessive exhaustion. The treatment must be conducted upon the same general principles as in carcinoma of the jaw.

CHAPTER XIII.

DISEASES AND INJURIES OF THE MOUTH AND THROAT.

SECT. I.—AFFECTIONS OF THE LIPS.

THE lips are liable to wounds, hypertrophy, cystic and vascular tumors, eversion of the mucous membrane, carcinoma, and congenital fissure.

1. *Wounds*.—Incised wounds of the lips, if treated with the twisted suture, readily unite by the adhesive process. To insure this, however, and also to prevent deformity from unseemly scars, the edges should be carefully cleansed, and approximated with the utmost accuracy. The bleeding may be considerable, but is effectually

arrested by the twisted suture, which is always preferable in this situation, both on this account and on every other, to the interrupted. The ligature is as improper here as in the operation for harelip. Lacerated, punctured, and gunshot wounds of the lips, are treated on the same principles as incised.

2. *Carbuncular Inflammation*.—The lip is occasionally the seat of a species of carbuncle, commencing, usually, without any assignable cause, at some particular spot, from which it rapidly spreads over the surrounding parts, and thence to the face and the lymphatic glands in front of the ears and at the base of the lower jaw. High constitutional excitement, of a typhoid character, with pyemia, follows; and, unless he is uncommonly fortunate, the patient soon perishes from exhaustion.

The chief local remedy, of course, is free incision, made, if possible, on the side of the mucous surface, in order to avoid disfiguring scars. The application of iodine and suitable internal means will assist in sustaining the system, and in preventing the spread of the disease.

In the New York Journal of Medicine and Surgery for May, 1854, Dr. Willard Parker has described what he calls a "Peculiar Form of Inflammation of the Lips and Face, resembling Malignant Pustule." In the three cases which illustrate his paper, the disease began in a pustule upon the lower lip, from which it gradually extended to the neighboring structures, as the cheeks, upper lip, nose, and neck, which soon became excessively hard, livid, painful, swollen, and finally gangrenous. The affection was characterized by unusual depression of the vital powers, and two of the cases speedily terminated fatally. The patients were young men, of temperate habits, and, at the time of the attack, in the enjoyment of good health, none having been exposed to any poisonous influence, either local or constitutional. From the symptoms which attended the disease, it is obvious that it bore a greater resemblance to carbuncle and malignant pustule, especially the latter, than to any other known affection.

3. *Ulcers*.—Ulcers of the lips are by no means infrequent, and they may be either common or specific. The former usually present themselves in the form of shallow fissures, cracks, or excoriations, as the result of disorder of the digestive apparatus, and readily yield to simple remedies, as blue mass, and a proper regulation of the diet, aided by mildly astringent lotions, Turner's cerate, or weak citrine ointment. In the more obstinate cases, active purgation, and the occasional application of the solid nitrate of silver, may be necessary.

The syphilitic ulcer of the lips is generally the result of direct inoculation, presenting itself as a primary sore upon the labial border. Occasionally, the disease begins at the commissure, but the lower lip, according to my experience, is much more prone to suffer than the upper. The chancre, commencing either as a little vesicle, crack, or fissure, soon spreads, involving the entire thickness of the lip, which becomes hard, stiff, and painful. The discharge is thin and unhealthy, and signs of constitutional involvement at length manifest themselves, especially enlargement of the lymphatic glands at the chin and base of the jaw, along with various cutaneous eruptions, as the papular and exanthematous. The treatment is the same as in chancre of the penis. When the ulcer is of a consecutive character, the proper internal remedy is iodide of potassium with bichloride of mercury.

4. *Hypertrophy*.—Hypertrophy occurs almost exclusively in the upper lip, in young, scrofulous subjects. I have seen it most frequently in females, but males are by no means exempt from it. The lip is hard, firm, rigid, and more than twice the natural thickness; the subcutaneous veins are unusually conspicuous; the skin is prone to ulceration; and the countenance has a singularly puffy and disfigured appearance. The disease is often associated with eruptions of the scalp, psorophthalmia, enlargement of the tonsils, and other marks of the strumous diathesis, and may last for months and even years, before it is finally eradicated. The most reliable diagnostic signs are the firm and rigid feel of the part, as ascertained by the thumb and finger, the obstinacy of the swelling, and the absence of disease of the gums and teeth, together with the peculiar state of the system just mentioned. Attention to the chylopoietic organs, the exhibition of iodide of iron, and the topical use of tincture of iodine, or a weak ointment of iodide of lead, constitute the means which have succeeded best in my own hands. Occasionally, the cure is greatly expedited by the application of a few leeches. In obstinate cases, a mild course of mercury

may be required. The operations which have been proposed, and occasionally performed, for the relief of this affection, are entirely unnecessary.

A very rare form of hypertrophy of the lip is occasionally met with, chiefly in young subjects, between the ages of fifteen and twenty-five, although it may be congenital, due mainly to an abnormal development of the mucous follicles, and their connecting cellular tissue, which is converted into a dense, firm, fibrous substance. The lymphatic vessels are frequently greatly enlarged, and sometimes form a well-marked, cavernous, spongy network. The glands vary in size from a mustard seed to that of a swan shot, and are so closely aggregated as to form a distinct tumor on each side of the middle line, of a deep red color. The inner surface of the tumor is dotted with numerous orifices, which are simply the mouths of the enlarged follicles, and which are constantly bedewed with mucous fluid, standing upon them in small drops. The fibrous structure of the skin is unnaturally dense, and the lining membrane is not only thickened, but often chapped, ulcerated, or fissured. The lip, which has a hard, tough, leathery feel, is very prominent, and is greatly everted at its free border, imparting a very unseemly expression to the countenance. Its external surface is generally normal. The affection is free from pain. The proper remedy is excision of an elliptical portion of the everted lip, including the enlarged glands, and approximation of the edges of the wound by the interrupted suture.

5. *Tumors*.—Morbid growths of the lips are uncommon, the most frequent being the cystic and vascular, while adenoid, fibroid, papillary, fatty, myxomatous, and sarcomatous are exceedingly rare. I am not aware that pure osseous or cartilaginous tumors have ever been observed, although instances of fibroma of the upper lip which contained masses of hyaline cartilage have been reported; and Sir James Paget refers to two cases of a combination of osteoma with adenoma in the same situation.

a. *Cystic Tumors*.—The cystic tumor is almost peculiar to the lower lip, on the inner surface of which it has its seat, as seen in fig. 374, from one of my patients. It is usually solitary, and depends essentially upon the obstruction of one of the glands which are found in such abundance in this situation. It is generally spherical in its shape, semipellucid, elastic, movable, and from the size of a cherry-stone to that of a walnut. Its walls are thin, but rather firm, and its cavity is occupied by a thick, glairy fluid, similar to the white of eggs. The ropiness of this fluid is sometimes remarkable, and cases occur in which it resembles the vitreous humor of the eye. The cystic tumor ordinarily forms without any assignable cause; its progress is slow, and it is seldom productive of much pain, the chief inconvenience which the patient experiences being a certain degree of stiffness of the lip. Sometimes it ulcerates and discharges its contents, when it is apt to become sore and tender. A similar but smaller tumor occasionally forms on the free margin of the upper lip. So far as I know, the first account of this disease was published in my *Elements of Pathological Anatomy*, in 1839.

Fig. 374.



Cystic Tumor of the Lower Lip.

In the early stage of this affection a cure may occasionally be effected by the application of the tincture of iodine, especially if the tumor is previously punctured, so as to afford an opportunity for the escape of its contents; but, in general, the most certain remedy is incision with enucleation of the cyst, which is always easily accomplished with the forceps. In old cases, when the cyst has contracted firm adhesions to the surrounding structures, a portion of it may be cut away, and the remainder cauterized with nitrate of silver. Unless perfect removal is effected, reproduction of the disease may be anticipated. When the tumor is seated on the free margin of the lip, the preferable operation is excision, on account of the difficulty of enucleation.

b. *Vascular Tumors*.—Both lips, but more particularly the upper, as seen in fig. 125, p. 223, are liable to vascular tumors, principally of the nature of congenital nævus. In one case, perhaps, there is a predominance of the arterial, in another of the venous, element, while in a third they are nearly equally balanced. When the arterial material abounds, the disease may possess all the characteristic features of aneurism by anastomosis, pulsating synchronously with the heart, and expanding under the influence

of the passions. The morbid growth may be limited to the skin or mucous membrane, or, as is more commonly the case, involve all the tissues of the lip, forming sometimes a mass of considerable extent and bulk. It is easily distinguished by its history, its soft, erectile character, its scarlet or purple color, and its freedom from pain and malignancy. The proper remedy is ligation when the tumor is small and superficial; excision when it is large and deep-seated.

γ. *Fibroid Tumors*.—Fibroid growths have been observed within the substance of the lips by Bruns, Pitha, and Heyfelder, and, by Middeldorpf, as a small, pedunculated, very vascular, elastic, florid excrescence on the vermilion border of the lower of these structures in a lad, sixteen years old. The intralabial cases occurred in females, aged, respectively, twenty-seven, thirty, and thirty-three years, the tumor in two being seated in the upper lip. The chief points of distinction are, the peculiar hardness of the tumor, the absence of pain, the tardy development, and the indisposition to ulcerate. The proper remedy is excision, except when the growth has a narrow footstalk, when it may easily be removed with the ligature.

δ. *Fatty Tumors*.—Of the fatty tumor in this situation I have never seen any examples, and I am not aware that it has been observed except by Auvert and Demarquay. The diagnosis is based upon its inelastic, doughy feel, its slow progress, and its entire freedom from pain. In the case of Auvert, the tumor, as large as an orange, was of five years' duration, very vascular, and seated in the upper lip, of a female, seventeen years of age.

ι. *Adenoid Tumors*.—Glandular labial tumors, presenting the same minute features as adenomas of the breast, have been met with in the upper lip by Sir William Lawrence, Mr. Lloyd, and Sir James Paget. They were imbedded in the substance of the lip; had a firm, tense, elastic feel; were painless, and grew slowly. Billroth has described an adenoma of the mucous glands of the cheek, near the angle of the mouth, which recurred thrice after excision.

ζ. *Papillary Tumors*.—Warts and horny excrescences of the lips are very infrequent. Many years ago I saw, in a man, twenty-nine years of age, a tumor of the latter description attached to the centre of the lower lip. It was about one inch in length, of a blackish color, and of the shape of a cock spur. As it occasioned no special inconvenience, surgical interference was declined. A man, seventy-one years old, a patient at the College Clinic, had a horny growth upon the lower lip, five-eighths of an inch long by one inch in circumference at its widest part. It had existed for three years, and, as it had latterly been the seat of sharp, lancinating pains, I removed it. The man himself had clipped it pretty regularly once a month, to check its progress.

6. *Epithelioma*.—It is a very singular and inexplicable fact that, while the upper lip is the exclusive seat of harelip, the lower lip suffers almost exclusively from carcinoma. Of 560 cases of epithelioma of the lips, derived from the practice of Sir Astley Cooper, Riberi, Thiersch, O. Weber, Billroth, Bruns, and Guy's Hospital, only 20, or about 3.5 per cent., occurred in the upper. I have myself witnessed the disease in the upper lip only twice in upwards of 100 cases.

The disease, which is most common after the fiftieth year—the fifty-fifth, according to my observations, being the average—occurs in both sexes, although much more frequently in men than in women. Thus, of 291 cases observed by Bruns, Riberi, Thiersch, Weber, and Billroth, 270 were males, and only 21 were females. It may begin either as a bluish, shot-like tumor, immediately beneath the mucous membrane, as a dark, warty excrescence, or as a small cleft, chap, or fissure. It always commences with proliferation of epithelial cells, either of the mucous network, labial, sweat, or sebaceous glands, or, as has been recently warmly contended by Dr. Koester, of Wurtzburg, of the endothelium of the lymphatic vessels. Be this as it may, the disease gradually extends to the other component elements of the lip, which often, in consequence, acquires an immense bulk. The part, at first, feels stiff and uncomfortable, it then becomes hard and rigid, and, finally, giving way at one or more points, it forms a large, ulcerated mass, having a foul, bleeding, fungous appearance. The pain, from the start, is characteristic, being lancinating, pricking, aching, burning, or scalding, and darting about in various directions with great rapidity. The open surface is the seat of a sanious, fetid, and irritating discharge, and, at times, of considerable hemorrhage. As the malady advances, it gradually invades the gums, jaws, and neighboring lymphatic glands; the teeth become loose and

finally drop from their sockets; the countenance exhibits a peculiar cadaverous aspect; the body progressively emaciates; and the poor patient is ultimately worn out by hectic irritation. The period at which death occurs ranges, on an average, from nine to eighteen months from the commencement of the malady.

The annexed sketch, fig. 375, shows this disease in its earlier stages, as a small, hard tubercle. Fig. 376, taken from one of my private cases, exhibits carcinoma of the lip in an open form, long after the occurrence of ulceration. The microscopical character of the malady is displayed in fig. 377, from a drawing by Dr. Da Costa.

The causes of epithelioma of the lip are unknown. Writers and teachers who profess to be deeply versed in the etiology of the affection have gravely referred its origin to the habit of smoking with a short clay pipe, which, becoming heated, irritates the mucous structures, and thus lays the foundation of the disease. Such an opinion would be entitled to respect, if it were not for the fact that the subjects of carcinoma of the lip often do not use tobacco in any form whatever, while thousands upon thousands of persons who smoke and chew inordinately never suffer from it at all. Although the causes of the

Fig. 375.



Epithelioma of the Lower Lip in its Earlier Stages.

Fig. 376.



Epithelioma of the Lower Lip in an Advanced Stage.

Fig. 377.



a. Papilla taken from an Epithelioma, magnified 250 Diameters. b. Separate Epithelial Cells.

disease are not understood, it is interesting to know that it is not always so fatal as carcinoma in other parts of the body; a circumstance no doubt due to the peculiar nature of the structures in which it occurs.

The only reliable remedy for this disease is *excision*, performed early and freely, while the local mischief is still, as it were, in its infancy. All other treatment here is as unavailing as in similar disease elsewhere, the only benefit which it can afford being palliation. When the tumor is superficial, and limited mainly to the prolalial surface, it may be removed by circumscribing it with an elliptical incision, as in fig. 378, the edges of which are afterwards neatly approximated by the interrupted suture; the parts heal by the first intention, and the cure is followed by hardly any deformity. When the involvement is more extensive, embracing the entire thickness of the lip, ablation is effected by two incisions, one on each side of the tumor, extending from the prolalial margin down towards the chin, where they meet at an acute angle, like the lines of the letter V, as in fig. 379. Provided the resulting chasm is not very great, the raw edges are placed in exact apposition, and retained by the twisted suture, as in the operation for harelip. The bleeding, which is sometimes considerable, is temporarily controlled by the finger of an assistant, and permanently by the contact of the raw tissues. Occasionally it is necessary to cut away nearly the whole lip, and yet it is remarkable what little deformity is produced. In such cases, approximation is, of course, not sought for; the bleeding

Fig. 378.

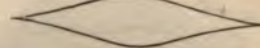


Fig. 379.



Excision of Epithelioma of the Lip.

vessels are secured by ligature; and the gap is left to granulate, like a common suppurating wound.

The period at which recurrence may be looked for after excision of this disease does not, in general, exceed five or six months. In a few instances I have known it to exceed several years. Hannover has related the case of a man in whom relapse did not occur for upwards of twelve years. He was operated upon, for the first time, in May, 1834, the disease having then already existed for two years. In 1846, the second excision was performed, the third in 1849, and the fourth in 1850, with good results up to 1852. Similar examples have been reported by Cline, Lloyd, and other surgeons.

In 1846, I excised the central portion of the lower lip, embracing fully one-half of its extent, on account of carcinoma in a gentleman, forty years of age. The tumor was about the size of a pigeon's egg, hard, firm, and the seat of sharp, lancinating pain. Six years after there was no return of the disease. In 1842, I assisted Dr. Dodson in extirpating the lip of a man fifty years old. The greater portion of the margin of the lip was indurated, and covered with a fungous growth, which had made its appearance seventeen months previously, in the form of a small wart. Ulceration at length set in; the pain was of a severe, burning, darting character, and the discharge was thin, sanious, and extremely fetid. The tumor was of a scirrhus consistence, and the incisions included nearly the entire lip, from one commissure to the other. There was no lymphatic involvement. I saw this man nine years after the operation, in perfect health. An eminent physician became affected with carcinoma of the lip in 1820. The disease continued to increase for six years, when it was destroyed by a powerful escharotic. Relapse occurring some time after, the affected parts were carefully excised, in 1830, by Professor Dudley, of Lexington. From that period there was no return of disease, and the gentleman finally died at an advanced age, upwards of twenty-five years after the operation. In a case recently sent to me by Dr. Miller, of Huntingdon, the patient, a man aged forty-nine, enjoyed an exemption from recurrence for upwards of thirteen years.

The result of my observation is that the disease is most liable to relapse when it is of rapid development, especially in young and middle-aged subjects. Speedy repullulation may always be anticipated when operative interference is postponed until ulceration has set in, or until there is involvement of the neighboring structures. But even here there is an occasional exception, as in an instance reported by Dr. Stout, of Easton, in which there was no recurrence of disease at the end of three years, although the entire lower lip and more than half of the upper, along with the central portion of the lower jaw, had been removed. The worst cases for operation are those in which there is marked lymphatic involvement.

7. *Eversion of the Mucous Membrane.*—This affection is peculiar to the upper lip, and may exist either as a congenital vice, as a consequence of simple hypertrophy from the habit of biting the part, or as the result of a preternatural elongation of the labial frenum. However induced, it presents itself in the form of a narrow, horizontal fold when the individual laughs, and gives the part the appearance of a double lip, as in fig. 380, from one of my patients. The deformity is remedied by removing an elliptical portion of the lining membrane, along with some of the glandular structures, and tacking together the edges of the wound with the interrupted suture. The operation is best done with the scissors. If the

Fig. 380.



Double Lip.

frenum alone is at fault, it should be duly abbreviated.

8. *Harelip.*—Harelip is a congenital cleft, so termed on account of its supposed resemblance to the lip of the hare. It exhibits itself in several varieties of form, from the merest fissure to the most horrible and disgusting chasm. It may be single or double, simple or complicated. The upper lip is almost exclusively its seat, and it affects the left side much oftener than the right. A mesial fissure is extremely rare, and probably never occurs without being accompanied by a lateral one.

In the most simple form of the defect, there is merely a fissure in the lip, extending from its inferior border as far up as the gum; its edges, of which the outer is always more or less oblique, are rounded off, covered by mucous membrane, and of a florid red color. Their consistence is considerably greater than that of the other labial structures, and, on being held together, they are seen to form, by their divergence below, a sort of triangle, the base of which corresponds with the free margin of the lip. In another class of cases the cleft is not only wider, but extends considerably higher up, perhaps even into the nose, which, in consequence, is usually somewhat flattened at the side, as seen in fig. 381, from a clinical case. The jaw in this, as in the former variety, is entirely normal.

Fig. 381.



Single Harelip.

Fig. 382.



Double Harelip.

In double harelip, fig. 382, there are, as the name implies, two fissures, with an intermediate central piece, which varies much in size, shape and direction, being sometimes broad and quadrangular, but more generally narrow, elongated, or mammillated. The framework of this part consists of two distinct portions, corresponding with the incisive bones of the inferior animals, and forming a rounded knob, connected by a narrow neck to the nasal septum. It is

commonly very oblique, sometimes, indeed, almost horizontal in its direction, is often very imperfectly covered by skin, contains the rudiments of the central incisor teeth, and almost invariably coexists with cleft palate and deformity of the nose. The fissures bounding this knob are not always of the same size and shape; on the contrary, one is frequently much wider, as well as longer and more curved, than the other. They may both extend into the nose, or one may do so, and the other, perhaps, not reach higher up than the gum. Figs. 383 and 384 represent the more common forms of the septum.

The complications of harelip are various, and deserving of attention. One of the most simple is that in which the labial fissure coexists with a depression, prominence, or cleft in the alveolar process of the jaw-bone. The cleft may be partial or complete; in the latter case, it is generally, if not invariably, connected with flattening and deformity of the corresponding side of the nose, and, not unfrequently, also, with fissure of the palate. In double harelip, the openings in the soft structures are almost always associated with malformation of the roof of the mouth. They pass round the central knob, at the posterior surface of which they become continuous with the palatine fissure, which generally extends both through the hard and soft parts as far as the extremity of the uvula. Dr. J. Mason Warren has described a case in which a double harelip was complicated with a median fissure of the alveolar arch and of the hard and soft palate.

Harelip is sometimes associated with other congenital malformations. I have witnessed its coexistence with clubfoot, bifid spine, and scrotal hernia, and lately I saw an instance where, along with a horrible cleft in the palate, there was great deformity

Fig. 383.



Fig. 384.



Deformity of the Jaw in Harelip.

of the hands, one of which was deprived of three fingers, and the other of one finger and the thumb.

Sir William Fergusson has described a very singular case of harelip in an infant, in whom a fissure on the left side of the upper lip, resembling that usually called harelip, coexisted with a fissure on the right side, extending from the angle of the mouth upwards and outwards, as far as the malar bone, without communicating with the nostril. The track was lined by mucous membrane, and there was a slight depression in the anterior wall of the antrum. The disfigurement was greatly increased by the defective condition of the left lower lid, which looked as if it had been torn and tacked to the eyeball.

Harelip is evidently the result of an arrest of development; but how this is produced has not been satisfactorily explained. Statistics show that it is more frequent in boys than in girls. Of 346 cases, collected by Mr. Thomas Smith, 210 were males, and 136 were females. In my own practice I have met with it nearly as often in one sex as in the other. It occasionally occurs in several members of the same family; and a case has been communicated to me by Dr. R. A. Lightfoot, of Kentucky, in which it has appeared in four successive generations, mostly in its double form.

Harelip, besides being very unseemly, and, consequently, an object of constant attention and remark on the part of others, interferes materially with sucking, deglutition, and articulation. In the worst grades of the affection, as when the fissure is double, or associated with cleft palate, it is often extremely difficult for the child to obtain the requisite amount of nourishment, much, if not most, of what is attempted to be swallowed regurgitating by the mouth. As he grows up, he finds himself unable to pronounce labial sounds, and thus, unless the defect is early remedied, his education must necessarily greatly suffer.

As to the proper age when the operation should be performed, nothing definite can be said. In the more simple cases, I do not hesitate to resort to it within a few days after birth, especially if the child is fat, plump, and well nourished; if, on the contrary, he is feeble, puny, anemic, jaundiced, or otherwise sickly, I postpone it until he is sufficiently strong and healthy to bear the shock and loss of blood, if it require weeks or even months to accomplish the object. It is great folly to attempt to lay down any specific rules for the conduct of the practitioner in such an affection. Every case must make its own laws, precisely as in every other operation, undertaken for the relief of malformation, disease, or accident. I always dread an operation for double harelip, especially when there are ugly complications, even when the child is perfectly sound and well-constituted. The operation then is a very grave one; the shock is frequently quite severe; there must always necessarily be a considerable loss of blood; and the resulting inflammation may be over-active; valid reasons, certainly, for the exercise of caution and judgment.

The existence of a cleft in the jaw is a strong inducement for early interference, experience having shown that the pressure exerted by the tightened lip upon the bone always promotes early closure.

During the operation the child's head is held firmly between the knees of the surgeon, the rest of the body being given in charge of an assistant. If he is very strong and restive, it may be necessary to wrap him up in a strong apron. The sitting posture may sometimes be advantageously adopted, the child being held upon the knees of an assistant, the head being nearly perpendicular and held securely by another assistant standing behind him. After long experience, however, I greatly prefer the first of these positions as best adapted to the object. There is no likelihood, if proper care be taken, that much, if any, blood will pass into the throat or windpipe. If the child is very unruly, he may be placed under the influence of chloroform, although such a course will seldom be required.

The operation, as it is usually performed, may be divided into three stages. In the first, the lip is extensively detached from the gums, sometimes as high up even as the nose, especially in bad cases. This I regard as a step of the greatest importance in regard to the form and beauty of the new lip, for so, in truth, it may be called. The second stage consists in paring the edges of the fissure, and the third in approximating them with the twisted suture. The instruments required are a narrow, sharp-pointed scalpel, a pair of scissors, forceps, a sponge mop, and a few small pins with glass heads.

The child being firmly secured, and the lip carefully detached from the gums, the edges of the fissure are pared with an ordinary bistoury, inserted at the upper angle

of the cleft and brought out at the lower. In executing this part of the operation, the serious error is frequently committed of removing too little substance, in consequence of which, when approximation is effected, there is an unsightly notch at the prolalial surface of the wound, which nothing short of another operation can efface. To obviate this occurrence, my invariable practice is to cut away the whole of the rounded portion of the fissure, and also, whenever there is a sufficiency of substance, to impart to the incisions a slightly curvilinear direction, so that the notch alluded to shall be effectually destroyed, and the lip receive its proper length.

Malgaigne, with a view of preventing the prolalial notch, which is so apt to follow the ordinary operation, especially when carelessly done, proposed to pare the edges of the fissure in such a manner as to leave two angular flaps below, which, when brought together, shall effectually obviate the defect. The procedure will be readily understood by reference to fig. 385. If, when the parts are healed, the flaps should be found to be redundant, they can easily be retrenched with the knife or scissors. The late Professor March, of Albany, used to accomplish the same object by means of a pair of forceps, each blade of which terminates in a transverse jaw, convex at its free extremity, and serrated within, so as to secure a better hold upon the lip.

The hemorrhage attendant upon the paring of the edges of the cleft is easily controlled by the thumb and finger of an assistant, or, what is preferable, a pair of compressing forceps. Compression of the facial artery as it passes over the body of the lower jaw also answers very well. If any blood falls into the mouth, it is at once removed with the finger, or a suitable spongemop.

The edges of the fissure, having been thoroughly refreshed, or, more properly speaking, excised, are accurately approximated, and retained by the twisted suture. Three pins, from an inch and a quarter to an inch and a half in length, according to the width of the gap, strong and well tempered, yet delicate, very sharp, and provided each with a glass head, are generally required. The first is inserted on a level with the red border of the lip, about three lines from the raw surface, and is brought out at a corresponding point on the opposite side, at least two-thirds of the thickness of the lip being in front of it. A strong silk thread, properly waxed, is then wrapped around it, not in the form of a figure 8, as usually recommended, but elliptically, as in fig. 386, and neither so firmly, on the one hand, as to create undue tension, nor so loosely, on the other, as to prevent perfect apposition. Another pin is passed, in the same manner, through the middle of the wound, and, finally, a third near its upper extremity, just below the nose. Sometimes two pins are quite sufficient, while, at other times, as many as four may be required. The ends of the threads must be passed from one pin to the other across the intervals, so as to subserve the purpose of adhesive strips; and the point of each instrument is then cut off with a pair of pliers, lest it should catch in the pillow, or hurt the little patient's hands. In performing this apparently trivial part of the operation, moderately firm pressure should be made upon the centre of each pin, otherwise it may, if not well tempered, break in the substance of the lip, and thus necessitate the introduction of another.

Some surgeons give the preference, in this operation, to the common interrupted suture, and there is no doubt that a good cure may occasionally be effected in this way, especially if the treatment be aided by a few narrow adhesive strips. I must say, however, after long experience, that I consider the twisted suture as altogether superior.

When single harelip is associated with inordinate deficiency of the soft parts, as it often is when it extends up into the nose, approximation of the edges of the wound may be greatly facilitated by separating the cheeks from their connection with the bones, and running, as has been suggested by Giraldès, incisions along the naso-labial furrows immediately below the alæ of the nose, thus enabling the operator, by a sliding movement, to elongate the lip, and give it a more natural position, shape, and appearance.

No dressing is required after the operation. The part is kept cool and quiet, to

Fig. 385.



Malgaigne's Operation, the Dotted Lines marking the Fissure.

Fig. 386.



Harelip Suture.

insure adhesive action ; and the child either takes the breast or is fed with the spoon, the most suitable diet being milk, broma, arrowroot, or some animal broth with soft-boiled rice. The upper and middle pins are withdrawn at the end of the second day, the lower one being left in twenty-four hours longer. The threads, which are always firmly glued to the lip by plastic matter, are permitted to drop off spontaneously, as they often perform excellent service in maintaining apposition after the more efficient means have been removed. If any portion of the wound remains open, it is touched lightly with a pencil of nitrate of silver ; or, if the gap is considerable, apposition is affected by the twisted suture, as in the first instance. If the chasm is very large, additional support is furnished by carrying a long, stout pin completely through the lip, at the distance of at least half an inch from each edge of the wound, a procedure far more efficacious than an adhesive strip, stretched across the cheeks.

The operation for *double harelip*, although conducted upon the same principles as in the single variety, must necessarily vary according to the nature of the concomitant deformity. If the intervening piece is vertical, or nearly so, completely covered by skin, and of proper length, all that is required is to close the fissures in the usual manner ; not generally, however, at one time, but after an interval of several weeks, unless the child is uncommonly strong and well developed, otherwise the shock and loss of blood will be likely to interfere with the adhesions. If, on the contrary, it is very oblique, or almost horizontal, an attempt should be made to rectify it by separating it carefully from the nose, and then pressing it back with a pair of stout forceps, or, as I ordinarily do, with the fingers, having previously incised it with a strong knife. The part is kept in place by means of a narrow strip of adhesive plaster, renewed from time to time ; and after it is thoroughly healed, its edges are pared and approximated in the usual fashion. The division of the septum is generally attended with considerable bleeding, which should, of course, be promptly checked.

When the intermaxillary septum is excessively deformed, it should be excised, either with the bone-nippers, a strong scalpel, or a small saw. Considerable hemorrhage, from the division of the artery of the nasal septum, usually attends the operation, but, in general, soon ceases spontaneously, or with the aid of a little pressure with the finger. Should it prove troublesome, it may be necessary to touch the bleeding orifice with a heated probe, or to apply a graduated compress and roller. In the latter case, the paring of the edges of the now large and single cleft must be postponed until the child has recovered from the effects of the operation. Removal of the intermaxillary septum in double harelip is not unattended with danger. I have heard of several instances in which it occasioned death.

It has been proposed, in double harelip, to rectify the vicious position of the central piece by systematic compression, made either with the finger or a spring-truss, not unlike an instrument used in the treatment of umbilical hernia. In my own practice, however, the procedure has not been attended with any benefit, and I believe that it will generally be found to be inapplicable, or wholly inefficient. In removing this structure, the nasal septum must not be encroached upon too much, otherwise the lip will inevitably have a flat and depressed appearance. Indeed, it is a good plan, in most cases, to retain a portion of it, for the purpose of supporting the soft parts ; and this may always be easily enough done if the bone is divided perpendicularly through the alveolar process, the teeth, if any protrude, having previously been extracted. When the patient has reached the proper age, the piece thus left, can readily be retrenched, and the chasm filled with an artificial jaw. Another circumstance, not to be neglected where removal of the intermediate body is demanded, is to save a portion of its cutaneous covering, this being properly shaped, and fastened, at the close of the operation, by several short, delicate needles, to the nasal septum, which it thus serves to render more prominent and seemly.

When the chasm is uncommonly large, as when the intervening substance has been removed, the tension of the parts may be so great as to require support. A most admirable contrivance for this purpose, sketched in fig. 387, has been devised by Mr. Hainsby, and is so arranged as to press each cheek over towards the middle line.

When the malformation is associated with a cleft in the alveolar process of the jaw, an attempt should be made to obliterate the latter, provided it is not very large, before we operate for the cure of the former. This may often be very satisfactorily accomplished, especially if the treatment is commenced within a few days after birth, by a plan suggested by the late Dr. Hüllihen, of Wheeling. It simply consists in the application of several layers of adhesive strips to each cheek, the inner ends

of which extend across the lip beneath the nose, where they are drawn together by ligatures, daily tightened until the opposite edges are brought into contact. The dressing, which need not be renewed oftener than once a week, does not interfere with sucking, and usually effects its object in from one to two months.

If this plan fail, or if the time for its successful employment has passed, the malformed portion of bone must be pressed forcibly backwards towards the mouth with a pair of strong forceps, protected with leather at the ends, to prevent confusion of the gums. Or, instead of this, a V-shaped portion of the septum may be cut out, the edges being approximated with silver wire suture. When union has taken place, the pedicle may be pushed back and retained in place by adhesive plaster stretched across the upper lip. If the artery of the septum should bleed, the orifices must be touched with the actual cautery, kept ready for the purpose. Excision must not be thought of, as this would deprive the lip of its natural support, and the jaw of some of its teeth.

When, by these efforts, approximation has been effected, the borders of the cleft should be carefully pared and united, as originally suggested by Dr. Fundenberg, of Maryland, by a strong ligature, passed through each side of the jaw, one-third of an inch from the edge of the fissure, and tied as firmly as possible while the two bones are pressed forcibly together by an assistant. The suture is retained for eight or ten days, the cheeks being supported in the interval by adhesive strips, arranged, as already indicated, or by means of Hainsby's compressor. This ingenious procedure is, of course, applicable only to very young children, before the osseous tissue has acquired much solidity.

A very singular case of congenital cleft of the left cheek came under my observation, in 1849, in a stout, healthy boy, four years of age. The fissure, which involved the corresponding commissure of the lips, was about one inch in length, by three-quarters of an inch in breadth. Its edges were rounded off, hard, red, and covered with mucous membrane, as in ordinary harelip. The child was unable to articulate distinctly, and experienced much difficulty in controlling his saliva, food, and drink. The parts, pared in the usual manner, were approximated with three twisted sutures, and united beautifully by the first intention. The improvement of the face was most satisfactory. The annexed sketch, fig. 388, gives an accurate idea of the face prior to the operation. Cases of macrostoma, as this defect is named, have been reported by Klein, La-roche, Ward, Colson, Langenbeck, Fergusson, Ashhurst, and others. Several instances have been observed, one, among others, by Miralt, in which the malformation was double, the cleft extending almost from one ear to the other.

9. *Lower Lip*.—It is extremely rare to meet with malformations of the lower lip. I have myself never seen any examples of congenital fissure here, and, with the exception of those recorded by Tronchin, Nicati, and Bouisson, I do not know that any have ever been observed. In all these instances the cleft seems to have been mesial.

A very curious malformation of the inferior lip, in the form of two little sacs, one on each side of the middle line, has been described by Dr. Jardine Murray as having occurred in four members of the same family, in three of which it was associated with harelip. The pouches, which occupied the margin of the lip, were half an inch in depth, of a crescentic shape, moistened with glairy mucus, and capable each of receiving a split pea. A similar case, also associated with double harelip, has been

Fig. 387.



Hainsby's Cheek Compressor.

Fig. 388.



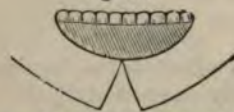
Fissure of the Cheek.

described by Richet. The canals were situated near the middle line, and extended through the entire length of the lip. The only remedy for such a defect, which, probably, essentially consists in a malformation of a muciparous gland, is thorough excision.

10. *Cheiloplasty*.—Extensive destruction of the lips sometimes occurs; generally as a result of malignant disease, accident, or sloughing from inordinate mercurialization, carbuncular inflammation, and other affections. The deficiency thus occasioned may generally be effectually closed by an autoplasmic operation, performed upon the same principle as in making a new nose, the integumental flap being borrowed from the immediate neighborhood of the gap. When the upper lip is affected, the flap is generally taken from the cheek, or partly from the cheek and partly from the neck. A similar procedure may be adopted when the outer portion of the lower lip is to be repaired, whereas, when the deficiency exists at its middle, the skin should be taken from the chin, the incisions, if need be, being carried as low down as the hyoid bone.

After removal of the lip on account of carcinomatous disease, an excellent substitute may generally be made by raising two quadrilateral flaps from the lower part of the face and the upper part of the neck, by carrying an incision on each side obliquely downwards, beneath the jaw, from the base of the gap, and then obliquely upwards and backwards, some distance beyond the commissure of the lip. A triangular

Fig. 389.



Lines of Incision in Cheiloplasty.

piece of skin is thus left at the middle line, the apex of which is directed upwards, and serves to mark the point of junction of the two flaps, after they have been dissected up, and stitched in place. The adjoining sketch, fig. 389, affords a good idea of the lines of incision, while fig. 390 exhibits the appearance of the parts after they have been united. The operation, which I have successfully performed in a number of instances, is usually known as that of Mr. Syme.

11. *Contraction of the Mouth*.—This defect is sometimes congenital, but much more frequently a result of disease, particularly of profuse and destructive pyalism. The contraction may amount almost to complete closure. However induced, it is both unseemly and inconvenient. In regard to the treatment of such a condition, no special rules can be laid down; the skill of the surgeon will generally indicate the course to be pursued in each particular case.

Fig. 390.



Cheiloplasty.

in each particular case.

SECT. II.—AFFECTIONS OF THE TONGUE.

The principal surgical affections of the tongue are wounds, inflammation, ulcers, hypertrophy, carcinoma, tumors, morbid adhesions, and malformation of its frenum.

1. *Wounds*.—Wounds of the tongue are most commonly produced by the teeth during epileptic convulsions; but they may also be inflicted by balls, and by design with sharp instruments. The hemorrhage, which, from the great vascularity of the organ, is often copious, is usually easily controlled by ligature, acupressure, and styptics, especially ice and subsulphate of iron. When it proceeds from the posterior portion of the tongue, it may be necessary to use the actual cautery. When the ranine artery is laid open, the surgeon may be compelled to tie the lingual artery above the great horn of the hyoid bone.

The edges of the wound are approximated by the interrupted suture, the only retentive means of which the parts admit; inflammation is kept in abeyance by anti-

phlogistics. Cases occasionally occur in which the tongue is almost completely severed, or in which the anterior extremity hangs only by a few shreds. Our duty obviously is to save the parts, not to cut them off; and with this view they should be closely approximated by numerous stitches, thus placing them in the most favorable position for speedy reunion. When the tongue manifests a tendency to fall back into the throat, so as to threaten suffocation, or when it has lost its support from the destruction of its muscles, as occasionally happens in gunshot and other injuries, the proper plan is to fasten it to the teeth, by means of silver wire, until the danger is over.

In gunshot wounds the ball occasionally lodges in the substance of the tongue, where it may remain undetected for a long time, the only evidence, perhaps, of its presence being a fistulous aperture, as in the case narrated by Boyer, where a body of this kind had been retained for four years. A similar instance has been reported by Moizin. The proper remedy, of course, is excision.

2. *Glossitis*.—Inflammation of the tongue, fig. 391, technically called glossitis, of a severe character, is often caused by lacerated wounds, and by the contact of hot water, steam, and various kinds of acids. Not unfrequently the organ suffers secondarily, from extension of disease in the surrounding parts, as the tonsils, palate, gums, teeth, and salivary glands. In common ptyalism, glossitis always exists; sometimes in a most violent degree. In the old method of treating syphilis, the tongue was often excessively inflamed, and so large as to protrude several inches beyond the teeth. However induced, the disease is frequently very severe, and, consequently, productive of immense distress, from the great swelling and tenderness of the parts, and the attendant suffocative symptoms. The patient is hardly able to talk or swallow, he pants for breath, and is an object of great pity. The tongue sometimes enlarges very suddenly, to an alarming extent, almost completely filling the mouth, and occasioning excessive embarrassment in respiration. The cause of the attack, which occurs chiefly in middle-aged and elderly subjects, is generally inscrutable. In some of the reported cases it was apparently dependent upon the effects of cold, or a sudden suppression of the cutaneous perspiration combined with gastric disorder. The swelling is characterized by copious and rapid effusion of serum and lymph.

Fig. 391.



Glossitis.

A very curious case of glossitis, in which only one symmetrical half of the tongue was affected, has been related by Dr. Graves in the Dublin Hospital Reports. The swelling was so enormous that it almost completely filled the mouth.

The treatment is strictly antiphlogistic. If the patient is young and robust, blood is taken freely from the arm, the bowels are thoroughly evacuated, and the system is brought under the full influence of nauseants. The best topical remedies are leeches, applied directly to the inflamed surface, or beneath the base of the jaw, followed by large emollient poultices. Bleeding from the ranine veins is sometimes beneficial. In the milder cases the disease often promptly yields to astringent lotions and to counter-irritation to the neck, in the form of embrocations and ammoniated liniments. When the inflammation is of an erysipelatous character, the tongue may be painted several times in the twenty-four hours with a weak solution of iodine, or pencilled once effectually during that period with the solid nitrate of silver. When suppuration, gangrene, or asphyxia is threatened, deep incisions are made, to favor disengagement of the overloaded vessels and the escape of the effused fluids. The operation, although followed by what might appear to be an alarming flow of blood, is free from danger, and is the only remedy which, in such an event, is worthy of reliance.

Glossitis consequent upon ptyalism is often a very painful and intractable disease. The tongue is generally much swollen, and of a fiery redness; patches of lymph form upon its surface, and not unfrequently ugly ulcers make their appearance, thus adding greatly to the patient's suffering. The treatment consists in the daily use of mild aperients, warm applications to the head and neck, and astringent gargles, of which the best, according to my observation, is a solution of acetate of lead, in the proportion of two drachms of the salt to a pint of water. With this the mouth and throat should be freely and frequently gargled. The only disadvantage of this

lotion is that it discolours the teeth, an effect which, however, generally disappears in a few days after the discontinuance of the remedy. When the lead disagrees, or proves inefficient, weak solutions of sulphate of copper, tannic acid, sulphate of zinc, chloride of iron, hydrochlorate of ammonia, or sulphate of alum may be employed as substitutes. When the tongue is very red and painful, ulcerated, or incrustated with lymph, the most suitable remedy is nitrate of silver, drawn lightly over the affected surface once a day.

In those sudden and violent forms of glossitis resulting from cold or gastric disorder, relief is attempted by copious bleeding at the arm, speedily followed by an active emetic; the bowels are freely opened, leeches are applied to the chin and side of the jaw, and the tongue is deeply scarified. If these measures fail, or there is impending suffocation, laryngotomy must be performed.

3. *Ulcers.*—Ulcers of a syphilitic, strumous, mercurial, and simple character often exist upon this organ, and require much judgment for their discrimination and treatment. The history of the case, the habits of the individual, and various other circumstances, will generally afford important information respecting their true nature. The simple ulcer is commonly associated with derangement of the digestive apparatus, and is usually easily distinguished from the other varieties of the affection by its superficial surface, by the slight discoloration of the adjacent parts, by the absence of induration, and by the readiness with which it yields to treatment. The syphilitic ulcer, described in the chapter on syphilis, has a hard base, a foul, irregular surface, more or less discharge, and a copper-colored appearance of the mucous membrane around, with great swelling, pain, and stiffness of the tongue. The scrofulous ulcer is uncommon, and not always easy of recognition. Its existence, however, may be suspected when there is an obstinate sore on the border of the tongue, near its centre, the edges of which are irregular, distinctly circumscribed, and, along with the bottom, infiltrated with lardaceous or caseous matter, which consists, microscopically, of gray and cheesy miliary tubercles. Its occurrence in young persons, with a tumid state of the upper lip, an enlarged abdomen, and other evidences of the strumous diathesis, is confirmatory of the diagnosis. A deep ulcer of the tongue may lay open the lingual artery, and thus cause severe, if not fatal, hemorrhage. These various ulcers sometimes present themselves in the form of rhagades, clefts, or fissures, extending to a considerable depth into the substance of the tongue. I have seen them upwards of an inch in length, and fully three-quarters of an inch deep, with steep, red, elevated edges, and a foul, unhealthy base. Such ulcers are usually caused by a syphilitic taint of the system.

The treatment is regulated by the nature of the disease upon which it depends. The syphilitic form is best managed by the exhibition of iodide of potassium, in combination with bichloride of mercury, and the application of nitrate of silver, or dilute acid nitrate of mercury. In strumous ulceration the chief remedies are cod-liver oil and the different preparations of iodine, either alone or in union with mercury. The mercurial variety generally requires no constitutional treatment, a cure being often effected in a few days by the topical use of nitrate of silver, sulphate of copper, acetate of zinc, and other astringent lotions. Similar means, especially the former, with attention to the state of the digestive organs, often succeed in the ordinary form of ulcer of the tongue. In all cases, whatever may be the nature of the exciting cause, the strictest attention should be paid to the diet, bowels, and secretions. This, indeed, is frequently of itself sufficient to effect a cure, while without it no treatment, however well conducted, will be likely to be of much avail.

The hemorrhage attendant upon ulceration of the tongue from perforation of the lingual artery is sometimes restrained with great difficulty. The best plan, as a general rule, is to try the effects of acupressure, aided with the subsulphate of iron. If this fail, the external or common carotid artery should be tied, as the lingual, from the depth and intricacy of its position, and its occasional irregularity, cannot, under such circumstances, be secured to advantage.

4. *Diphtheritis.*—A diphtheritic state of the tongue is sometimes observed. It is noticed most frequently in the latter stages of chronic diseases of a malignant or incurable character, accompanied with an anemic condition of the system. It is evidently of an inflammatory nature, and is nearly always associated with soreness of the fauces and pharynx. The tongue is usually somewhat tender and swollen, with a feeling of rawness, or a sense of scalding, and is covered with a thin layer of adherent lymph, of a whitish, grayish, or drab color. The crust sometimes extends

over the whole surface of the organ, at other times it occurs in small spots, strips, or patches. The gums, cheeks, lips, roof of the mouth, and even the fauces, occasionally participate in the deposit. On removing this substance, the mucous membrane is found to be somewhat rough, and heightened in color, with, perhaps, here and there a slight fissure, abrasion, or ulcer. A diphtheritic state of the tongue is occasionally produced by salivation.

The treatment is mildly antiphlogistic, reliance being placed mainly upon local measures. Weak washes of sulphate of copper and tannic acid, with honey, nitrate of silver, and sulphate of zinc, are generally sufficient to detach the diphtheritic crust and to remove the inflammation which causes it. Very frequently the best effects follow the employment of a strong gargle of borate of soda, or the application of equal parts of this substance and of powdered sugar, aided by the exhibition of chlorate of potassa.

5. *Paralysis*.—Organic palsy of this organ, first described by Duchenne, occasionally exists by itself, but most generally it is associated with a similar condition of the lips, palate, œsophagus, and even the larynx, and obviously belongs to that variety of disease now recognized as progressive muscular paralysis. It is usually, as the name implies, gradual in its approaches, and is essentially characterized by imperfect movements of the affected parts, as indistinctness in the pronunciation of words and letters; inability to pucker the lips, as in whistling; difficulty of deglutition, of clearing the throat and larynx, and of turning the food in eating; escape of food and drink by the nose; an unusually quiescent state of the mouth in talking; trouble in spitting; and other phenomena of muscular weakness. The affection, although most common in elderly subjects, is sometimes noticed at a comparatively early period of life, and not unfrequently occurs in combination with paralysis of the extremities, especially the inferior.

In the advanced stages of the complaint, the tongue is sometimes completely paralyzed, as well as partially insensible; and the patient finally perishes from inanition, in consequence of his inability to swallow. The cervical, hypoglossal, and glossopharyngeal nerves are atrophied, but the muscles of the tongue, lips, face, and palate present no appreciable lesion. The superior extremity of the spinal cord is occasionally softened and more or less wasted.

Little, if, indeed, anything, is to be expected from treatment. The indication, obviously, is to sustain the patient's strength by means of tonics and a generous diet, which is all that can be done, as there are no medicines which, so far as is at present known, are capable of arresting the morbid action upon which the paralysis depends. Electricity has been recommended, but is unworthy of reliance.

6. *Neuralgia*.—Although neuralgia of the tongue may exist as an independent affection, it is usually associated with similar disease of the jaws, teeth, and face, and is characterized by the usual phenomena. In a majority of the cases that have come under my observation, the malady occurred in elderly subjects, and my impression is that women are more liable to it than men, especially such as are of a nervous, hysterical temperament. The paroxysms are often extremely violent and protracted; now and then, however, there are intervals of comparative ease, for days, and even weeks, although this is uncommon. Every movement of the tongue is attended with intense agony; hence, speaking, eating, and drinking are performed with great difficulty and suffering. The pain is usually confined to one side of the organ, which, in other respects, is generally perfectly sound, and there is nearly always a sense of numbness and stiffness in the corresponding cheek and lip.

The cause of neuralgia of this organ is seldom appreciable. Occasionally it is evidently dependent upon disease of the teeth, or disorder of the digestive apparatus; and cases occur in which it is plainly traceable to miasmatic influences.

When the ordinary antineuralgic remedies, as quinine, morphia, strychnia, and arsenic, fail, the only resource is excision of a portion of the lingual nerve, an operation attended with the most happy results in the hands of Vanzetti, and several other surgeons. The tongue being pulled forwards and to the opposite side, the nerve is exposed as far back as the border of the internal pterygoid muscle, by an incision carried through the mucous membrane backwards and slightly downwards from the prominent ridge behind the last molar tooth. It is then excised to the extent of at least one inch, as was done in the interesting case of Vanzetti, with instantaneous and permanent relief.

7. *Hypertrophy*.—Hypertrophy of the tongue, constituting what is called macro-

glossa, may be limited to its muscular substance, to its papillæ, or to its mucous investment; or, as not unfrequently happens, all these structures, along with the lymphatic vessels, which form a cavernous network in the connective tissue, may be simultaneously affected, as in fig. 392, constituting general hypertrophy. In the latter case, which mainly concerns the surgeon, the organ is abnormally dense, rigid, and so large as to protrude considerably beyond the teeth, causing serious obstruction to the functions of the mouth, and a wasting discharge of saliva. The prolapsed

Fig. 392.



Hypertrophy of the Tongue.

Fig. 393.



Microscopical Characters of Hypertrophy of the Tongue.

part is from a few lines to three, four, and even five inches in length, by several inches in breadth and thickness, rough on the surface, preternaturally firm, and of a dark color. The papillæ are often five or six times as large as in the normal state, and the mucous covering has more of the character of bark than of sound structure. The microscopical characters of the affection are well illustrated in fig. 393, from a clinical case, in a child three years of age.

The affection, which is more common in females than in males, generally comes on early in life, being now and then, if, indeed, not always, congenital. The exciting cause is unknown, although occasionally it is directly traceable to inflammation. It is sometimes associated with unusual shortness of the branches of the lower jaw, and with great separation of the incisor teeth. Enlargements of this kind are often extremely vascular, from undue development of their minute vessels; and dissection shows that their muscular fibres are transformed into a pale, dense, fibrous substance, with hardly any trace of the normal structure.

The nature of this disease is always easily detected by simple inspection. Its progress is generally tardy, and free from pain and inconvenience, save what results from the bulk of the affected part. When this is considerable, the saliva dribbles constantly from the mouth, and the patient finds it difficult to articulate, chew, and swallow. The countenance has an unseemly aspect, the inferior incisors are forced into a horizontal position, and the jaw itself is not unfrequently considerably altered in its shape. The general health is remarkably prone to derangement, and a not uncommon symptom is disorder of the digestive apparatus.

Very little is to be expected from purely medical treatment in this affection, especially when fully developed. In the milder grades, marked benefit occasionally follows regular and systematic purgation, low diet, and the exhibition of iodide of iron, iodide of potassium, or Lugol's solution. When the disease is of inflammatory origin, alterative doses of mercury may occasionally be advantageously conjoined with these remedies, but in the congenital variety little is to be expected from such a union. The most valuable local applications are leeches, punctures, or small incisions, and tolerably strong solutions of iodine, sulphate of copper, and kindred articles. I had lately under my care a lad, aged six years, affected with congenital hypertrophy of the tongue, who was materially benefited by lotions of pyroligneous

acid, in the proportion of one drachm to the ounce of water. Under its influence, the protruded portion of the organ became much softer, as well as considerably reduced in volume. Lassus derived great benefit from systematic compression of the tongue by means of a bandage, and a case, treated successfully upon this plan, has been related by Professor Syme. If these means fail, the exuberant structures are removed by the knife, ligature, or *écraseur*, as in carcinoma.

The *papillæ* of the tongue are not often subjects of surgical interest. Their principal disease is hypertrophy or chronic enlargement, either in conjunction with, or independently of, the rest of the organ. The circumvallate *papillæ* sometimes increase to a very considerable bulk, forming little tumors of the size of small peas, studding the surface of the mucous membrane; they are of a reddish, gray, or ash color, of a tolerably firm consistence, and but slightly, if at all, sensitive. The filiform *papillæ* are liable to a peculiar capilliform elongation, their length being from six to eight lines greater than in the normal state, without any augmentation of their diameter. They look, in fact, like so many hairs. They are soft, of a dirty-drab or brownish hue, and arranged in such a manner as to overlap each other like the pile of long velvet. The changes of both these classes of *papillæ* are generally indicative of disorder of the digestive apparatus, and they readily yield under a mild alterative and tonic course of treatment, aided by the gentle application of the solid nitrate of silver. When the filiform *papillæ* are much enlarged, they may be clipped with the scissors.

The different classes of *papillæ* are sometimes very tender, more or less inflamed, and exquisitely sensitive, from the denudation, apparently, of their epithelial investment. The best remedies are astringent lotions and nitrate of silver, together with attention to the nature of the exciting cause.

8. *Atrophy*.—Atrophy of this organ is singularly uncommon. It has occasionally been noticed as a congenital defect, in association with other vices of formation; but, in most of the recorded cases, it was evidently dependent upon the pressure of some morbid growth, either of the tongue itself or of some neighboring structure. The wasting exists in various degrees, and is liable to be followed by impairment of the sense of taste, and other functional disorder. A remarkable case has been described by Dupuytren, in which the atrophy was caused by paralysis of the tongue by a collection at the base of the cerebellum of a number of hydatids, one of which had insinuated itself into the anterior condyloid foramen, and compressed the lingual nerve. The sense of taste had remained intact during the two years in which the patient was in this condition. Science has found out no remedy for atrophy of the tongue, however induced.

9. *Carcinoma*.—Carcinoma of the tongue usually exhibits itself in the form of scirrhus, or what is now called epithelioma; encephaloid is extremely rare, and colloid is entirely unknown. The same is true of melanosis.

Epithelioma of this organ is most frequent in males after the age of fifty. Of 19 cases reported by Dr. J. Hutchinson, the average age was fifty-four, the extremes being thirty-two and seventy-eight. In 16 cases observed by Dr. Humphry, 11 were above and 5 under fifty years. The disease generally arises without any assignable cause. The contact of a carious tooth or broken fang, and of the stem of the pipe in smoking, has been accused of originating it, but the idea is far-fetched and insusceptible of proof.

The disease is most commonly situated towards the centre of the tongue, midway between the *raphé* and one of its edges, where it begins either as a minute, hard, and elastic tubercle, a small, fungous excrescence, or a little sore, chap, or fissure. However this may be, it gradually spreads, and at length degenerates into a foul, excavated ulcer, with indurated, jagged, and elevated edges. The parts around are hard and firm, and not unfrequently the whole organ is as stiff and immovable as a board. The pain, which is sharp and pricking, or dull and aching, is particularly severe at night, and generally radiates about in different directions, especially along the cheeks, ears, and temples. Occasionally it is of a neuralgic character. The size of the affected organ is liable to much diversity; sometimes it is normal, but more commonly it is considerably augmented, and sometimes, again, it is a good deal diminished. In a case recently under my observation, it presented itself as a firm, hard, immovable mass, which accurately filled the trough formed by the dental arch of the lower jaw. At times the organ is so large as to project beyond the lips and to encroach seriously upon the buccal cavity. Its color is usually somewhat height-

ened, and its edges are often indented by the teeth. As the malady advances, deglutition becomes embarrassed, from the fact that the food can no longer be collected and carried back into the throat; articulation is impaired; and sputation is so frequent and difficult as to constitute a source of real suffering. By and by, the lymphatic glands at the base of the jaw enlarge; the gums swell, and present a red, spongy aspect; the teeth loosen and fall out; and the system exhibits all the marks of the carcinomatous cachexia. Thus, day by day the ruthless malady proceeds, until it has effectually accomplished its work of destruction. Sometimes other organs are involved in its progress, but most commonly the carcinomatous action is limited to its original site and neighborhood.

In two remarkable cases of this affection recently under my observation, the morbid action evidently took its rise in the frenum of the tongue, from which it eventually spread to the tip of this organ, the gums, jaw, and lower lip, as well as to the neighboring lymphatic glands. The disease came on without any assignable cause, and occasioned the most frightful suffering. The patients, both males, were respectively, twenty-six and fifty-four years of age. Death in both occurred in less than fifteen months from the commencement of the attack.

The diagnosis of carcinoma of the tongue is seldom difficult. The mode of origin of the malady, its slow but steady progress, its resistance to treatment, the peculiar character of the resulting ulcer, the nature of the pain, the age of the patient, and the sure contamination of the adjacent parts, if not also of the general system, always serve to distinguish it from other affections incident to this organ. The disease with which it is most liable to be mistaken is syphilis, and, unless great care is exercised, serious errors of diagnosis may be committed. In a case lately under my charge, the tongue had been condemned by several able practitioners on account of what one supposed to be carcinoma but which proved to be nothing but syphilis. The ulcer, which formed a deep, narrow gutter, extended along the left side of the organ from its root to near its tip, and entirely disappeared in less than a fortnight under the use of iodide of sodium and bichloride of mercury. The diagnosis was easily determined by the coexistence of an ulcer on the corresponding tonsil and a node upon the tibia.

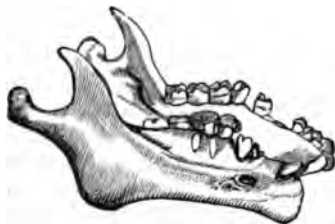
The treatment of this disease was generally, at least until lately, by ablation, either by the knife or ligature. The utility of such a proceeding, however, admits of great doubt, and my own opinion has long been that the less we interfere with it in this way the better. The results of my experience are certainly strongly corroborative of this conclusion. The ordinary means for improving the general health, allaying pain, neutralizing fetor, and preventing the spread of the disease, are, of course, not neglected. With judicious management, it is astonishing how long, in many cases, the disease may be kept in abeyance, and the final issue warded off.

With a view of preventing the excessive pain and the inordinate flow of saliva, both so distressing in this disease, Mr. Hilton has proposed to divide the gustatory nerve as it runs along the ramus of the jaw, and the operation has so often been performed with advantage as to merit repetition. Mr. Moore has modified the proceeding by combining with it ligation of the corresponding lingual artery, so as to deprive the affected part as effectually as possible of blood. The nerve is easily divided with a curved bistoury, as it lies in the shallow groove by the side of the ramus of the jaw, just beyond and within the last molar tooth. The incision should be superficial, and not more than three-quarters of an inch in length.

10. *Erectile Tumors*.—The tongue is occasionally the seat of the erectile tumor.

Its most common site is the anterior extremity of the organ, where it presents itself as a soft, elastic structure, of a bluish color, variable in form and size, free from pain, and subject to temporary enlargement under mental emotion. The disease is most frequent in young subjects, and is occasionally associated with similar developments in other parts of the body, as the lip and cheek. The tumor seldom acquires large bulk, but now and then an instance is seen in which it greatly encroaches upon the mouth, and by its pressure expands the jaw, as in fig. 394, pushing the teeth out of their natural position and even from their sockets.

Fig. 394.



Expansion of the Lower Jaw from Pressure by the Tongue, enlarged by Erectile Tissue.

If seen in time, the morbid growth is readily amenable to treatment. The best application is the Vienna paste, used as in making an issue, only with more caution, the organ being drawn forward and steadied the while by a volsella. Or, if the abnormal structure is limited and accessible, it may be removed by ligature, in the same manner as a carcinomatous tumor. Ablation may also be safely and conveniently effected with the *écraseur*. Deligation of the lingual arteries has been practised, but with no encouraging results. In one case, at least, the operation was followed by fatal sloughing.

Dr. Fayrer, of Calcutta, has reported a unique case of what he considered as a cirroid aneurism of the lingual artery, in a man, forty years of age. He found a tortuous, lobulated tumor, partly livid and partly whitish, about the size of a small orange, lying by the side of the frenum of the tongue, pulsating strongly when compressed between the thumb and finger, subject to attacks of violent hemorrhage, and of eight years' standing, with a steadily increasing tendency. A strong solution of tannic acid was injected, with the immediate effect of arresting the pulsation, and of coagulating the contents of the tumor; but the man disappeared before the completion of the cure.

11. *Papillary Tumors*.—A wart-like excrescence sometimes grows from the tongue; generally from its sides or tip, of a red color, firm consistence, painless, benign, tardy in its development, and seldom exceeding the volume of a small pea or raspberry. It is usually attached by a narrow pedicle, and is somewhat rough on the surface, its structure being of a fibroid character, intermingled with a large number of epithelial cells. The microscopical appearances of a growth of this kind, which I removed from a patient at the College Clinic, are represented in fig. 395, from a drawing by Dr. Packard.

The proper remedy for this growth is excision, or ligation, if there is reason to anticipate much bleeding. When small and recent, it generally yields very readily under the application of chromic acid.

12. *Cystic Tumors*.—This affection of the tongue is rare. It consists, as the name implies, of sacs, single or multiple, occupying the muscular substance, and elevating the mucous investment in the form of little tumors, of a semitransparent appearance, and occasionally quite sensitive. Dependent upon enlargement of the lingual glands, they vary much in size, but usually do not exceed the volume of a cherry-stone, and their number sometimes amounts to several dozens. Occasionally, a solitary cyst of considerable dimensions is observed. The most remarkable case of the kind that I have ever witnessed was sent to me at the College Clinic, in 1859, by Dr. Turnbull. The subject was a small, puny child, three weeks old, whose tongue was so large as to project fully two inches from the mouth, forming a thick, ungainly-looking mass, pellucid, soft, fluctuating, and effectually preventing sucking. The contents of the tumor were of a thick, ropy consistence, and of a whitish hue.

Cystic disease of the tongue is of obscure origin, and not always easy of recognition. Indeed, it is only when the vesicles approach the surface that its true character can be indubitably established. In cases of uncertainty, the exploring needle should be used. The treatment is by incision, injection, or seton, according to the age, structure, and volume of the tumors.

13. *Fibrous Tumors*.—Tumors of a fibrous structure are sometimes found in the tongue, either imbedded in its substance, or attached to its surface. They are generally of a spherical or ovoidal form, hard and firm in their consistence, free from pain, and of tardy, painless development. When they spring from the surface of the organ, they usually present a peculiar pendulous, polypoid appearance, their connection being effected by a narrow, slender pedicle. The fibrous tumor of the tongue is occasionally congenital.

Fig. 395.



Warty Tumor of the Tongue, Magnified 472 Diameters.

In a remarkable case of this kind, under my observation, in 1865, in a girl sixteen years of age, the tumor, which was of irregular form, somewhat elastic to the touch, and of a grayish color, was situated on the posterior part of the tongue, immediately in front of the epiglottis, and so completely filled the fauces as to interfere considerably with respiration and deglutition. It had a very broad, firm attachment, and its surface was traversed by large vessels. When first noticed, five years previously, it was hardly the size of an ordinary pea. The surrounding parts were unaltered, and the general health was good. The case afterwards fell into the hands of Dr. William Hunt, who strangulated the greater portion of the tumor with a double ligature. Unfavorable symptoms occurred soon after the operation, and the girl died on the third day, apparently from cerebral disease.

14. *Fatty Tumors*.—Only a few instances of the existence of fatty tumors of the tongue have been recorded. More commonly they are situated beneath the organ, over the sublingual gland, where they may acquire the bulk of a large marble, or even of a pullet's egg, as in a case which came under my observation many years ago, in a youth of nineteen. The mass was of an ovoidal shape, of a yellowish aspect, movable, and free from pain, but productive of considerable impediment in speech and mastication by its pressure against the tongue. After removal, which was easily effected, without any loss of blood, it exhibited all the characteristics of a fatty tumor.

15. *Cartilaginous Tumors*.—Enchondroma is the most infrequent of all the innocent tumors of the tongue, the only examples of the affection of which I have any knowledge being those referred to by Professor O. Weber as having occurred to himself and to Velpeau. In the case of a girl, fifteen years of age, which also came under his observation, an intralingual growth, of eight years' standing, and of the size of a walnut, proved to be a lipoma combined with enchondroma.

16. *Sarcomatous Tumors*.—Sarcoma of the tongue must be regarded as a surgical curiosity. Early in 1872 I met with a formation of this description in a delicate female child, seven months old. The tumor, which was first noticed about five weeks previously, occupied the back part of the organ, from which, in its progress, it gradually extended forwards over its middle, greatly impeding sucking and even deglutition. It was of a firm, dense consistence, apparently free from pain, and situated immediately beneath the mucous membrane, which retained its normal appearance, except that it presented a few large, straggling veins. The tumor had latterly so rapidly increased in size as to cause serious respiratory difficulty, and at the time of the operation it was of the volume of a large almond with its shell. Removal was effected by evulsion with the index finger, used as a kind of hook. As a matter of precaution a ligature was thrown around its anterior extremity. No bad effects followed. The tumor must have either been congenital, or have come on soon after birth. It was of an ovoidal shape, bilobed, or constricted towards its narrow extremity, smooth, and elastic, here and there interspersed with calcareous matter, and composed of spindle and large round cells.

A case of congenital tumor of the tongue, in which the anterior portion of that organ was removed with the galvanic cautery, in a child ten weeks of age, has been reported by Dr. Jacobi in the New York Medical Record, for May, 1869. The growth, about the size of a walnut, was of a cysto-sarcomatous nature, and contained numerous spindle cells, intermixed with capillaries and connective tissue.

17. *Morbid Adhesions*.—The tongue, in consequence of injury of the jaw, or of injury, inflammation, or ulceration of its own substance, is liable to form adhesions to the floor of the mouth and to the inside of the cheeks, thus greatly impeding the functions of speech, mastication, and deglutition. The bands, which may be single or multiple, vary in extent, from a few lines to upwards of an inch, and in consistence from that of fibrous tissue to fibro-cartilage, according to their age and other circumstances. Relief is afforded with the knife, a tedious, bloody, and painful dissection being sometimes necessary to accomplish the object. Reunion is prevented, during the cicatrization, by the interposition of charpie, or, what is better, tin-foil.

18. *Partial Immobility*.—The muscles of the tongue are liable to a species of contraction similar to that which occurs in wryneck and other affections. The cause is generally inflammation, attended with plastic deposits, ultimately followed, especially when the case is protracted, by fatty or fibroid degeneration, and inducing thus more or less impediment in the movements of the organ. In one case under my care, the patient found it difficult to seize and masticate his food, owing

mainly to the contracted and indurated state of the stylo-glossal and hyo-glossal muscles, the subcutaneous division of which at once relieved the parts of their constraint, and restored the tongue to its primitive mobility. Care must be taken, in performing operations of this kind, not to interfere with the proper lingual arteries.

19. *Malformations of the Frenum.*—The tongue is sometimes restrained in its movements by malformation of its frenum, impeding, at first, suction, and afterwards, articulation. The defect may consist in a short, indurated, and thickened condition of the part, or the little membrane may be prolonged so far forward as to interfere with the action of the tip of the organ; in either case demanding instrumental treatment. The operation, although simple, should not be performed wantonly, particularly as it is occasionally followed by hemorrhage. When necessary, the child's head is held between the knees of the surgeon, who, elevating the tongue with the index and middle fingers of the left hand, carefully divides the frenum to the requisite extent with a pair of narrow-bladed, blunt-pointed scissors, the extremity of which is directed downwards, away from the ranine vessels, the great source of danger. The little patient is watched for some time after the operation, lest undue bleeding should ensue.

The frenum of the tongue is sometimes entirely absent, allowing the organ to fall back into the fauces, where, when the parts are quiescent, it looks like a fleshy tumor, attached to the pillars of the palate by a reflection of the mucous membrane. Bransby B. Cooper met with two instances of this kind in the same family. One of the children died from suffocation, at the age of eighteen months, and the other had been repeatedly threatened with a similar accident, the respiration being particularly embarrassed during sleep. When sucking, the muscles seemed capable of retaining the tongue in its proper position. In such a case, an attempt might be made, after paring the lower surface of the organ, to stitch it to the floor of the mouth, although it is not probable that the operation would be successful.

20. *Ablation of the Tongue.*—Ablation of the tongue is sometimes required. The operation may be performed with the knife, ligature, galvanic cauter, or *écraseur*, as may seem most expedient. If the affected part is small, and involves the anterior extremity of the organ, it may be included in two incisions, meeting behind at an acute angle, like the lines of the letter V. The edges of the wound are brought together by the common interrupted suture, which serves the double purpose of a retentive and hemostatic agent. If, on the other hand, the disease, from its remote site, is less accessible, a decided preference is given to the ligature, as its use is unattended by hemorrhage. An instrument, such as that represented in fig. 396, armed with a strong, well-

Fig. 396.



Curved Needle for Ablation of the Tongue.

waxed double ligature, or a stout needle, slightly curved, and fixed in a movable handle, is passed through the tongue, from below upwards, on the inner side of the tumor; the noose of the cord having been cut, one portion of it is tied forcibly in front, and the other behind, thus completely isolating and strangulating the diseased structure, as seen in fig. 397. The effect will be the more rapid if the parts to be ligated are previously a little notched with the bistoury; and the pain of the operation may be greatly lessened by the adoption of Mr. Hilton's suggestion of dividing, as a preliminary step, the gustatory nerve. In a few days the eschar separates, leaving an extensive ulcer, which fills up rapidly with granulations.

In order to avoid the hemorrhage attendant upon excision of portions of the tongue and do away with the more tedious operation by the ligature, Chassaignac has proposed the substitution of the *écraseur*, applied in the manner

Fig. 397.



Ligation of the Tongue.

Fig. 398.

Removal of the Tongue with the
Écraseur.

years; and a large number suffered from relapse of the disease in the lymphatic glands of the jaw and other structures. The loss of speech is generally scarcely noticeable by ordinary observers. The great advantage of the operation is, not so much the prolongation of life, as the temporary exemption from suffering which it secures.

There are several methods by which this object may be effected, each, apparently, possessing some advantages over the other. That of Regnoli undoubtedly affords

Fig. 399.



Lines of Incision in Regnoli's Operation.

delineated in fig. 398. Ample experience, however, has demonstrated that the instrument cannot always be relied on as a preventive of bleeding, as it frequently occasions as profuse loss of blood as the knife. A much more expeditious and safer operation, under these circumstances, is that by the galvanic cautery, which has been successfully resorted to on several occasions by Mr. Hilton.

The remarkable feat of excising the entire tongue has now been repeatedly performed, especially in Europe, chiefly on account of epithelioma, by Syme, Regnoli, Rizzoli, Hugier, Sédillot, Maisonneuve, Fiddes, Nunneley, Ried, Paget, Erichsen, Fenwick, and other surgeons. Of 40 cases, kindly analyzed for me by Dr. O. H. Allis, of this city, death was attributable to the operation only in 6, in 4 of which Syme's method was employed. The majority of the patients experienced immediate relief from pain; a few survived several

years; and a large number suffered from relapse of the disease in the lymphatic glands of the jaw and other structures. The loss of speech is generally scarcely noticeable by ordinary observers. The great advantage of the operation is, not so much the prolongation of life, as the temporary exemption from suffering which it secures.

There are several methods by which this object may be effected, each, apparently, possessing some advantages over the other. That of Regnoli undoubtedly affords the most ready access to the affected organ, but it labors under the disadvantage of leaving a very large and dangerous wound. It consists, as may be seen by a reference to fig. 399, in carrying a crescentic incision along the base of the lower jaw, extending nearly from one angle to the other; then making a vertical incision from the centre of this along the median line to the hyoid bone; reflecting the flaps outwards and downwards; dividing the attachments of the lingual and hyoid muscles to the inner surface of the bone, and drawing the tongue through the large opening thus formed, when it is removed by the écraseur or knife carried through the sound tissues. The vessels are secured as fast as they are divided, and the parts are approximated in the usual manner.

In the operation of Mr. Syme, an incision is carried through the lower lip as far down as the hyoid bone, and the jaw sawed through the symphysis, one of the incisors having previously been extracted.

The finger being now insinuated under the tongue as a guide to the knife, the mucous membrane of the mouth is freely divided, and the muscular attachments of the diseased organ severed until the lingual arteries are brought into view, which are at once cut and secured, or, as suggested by Fiddes, of Jamaica, they are divided and tied in succession, thereby avoiding serious loss of blood. The tongue is then removed close to the hyoid bone, the bleeding vessels are ligated, and the edges of the incisions, both in the bone and soft parts, are approximated by silver sutures. Instead of excising the organ with the knife, the écraseur may be employed, as was successfully done by Mr. Heath. The principal objection to this operation is its interference with the lower jaw, which must always embarrass the after-treatment and seriously protract the cure. Of 13 cases, 3 of which occurred in the practice of its originator, 4 were fatal, the mortality being greater by 26 per cent. than after the operation of Mr. Nunneley.

In operating with the écraseur, a slight incision, hardly extending beyond a puncture, is made, as first practised by the late Mr. Nunneley, of Leeds, with a stout, sharp-pointed bistoury, along the middle line of the neck, a little nearer to the base of the jaw than the hyoid bone, into the mouth, until the knife appears at the frenum of the tongue. The twisted wire-rope or chain of the instrument, which follows the track

of the wound, is then carried well back and spread over the base of the organ, the tip of which, drawn through the loop, is seized with a strong volsella, and pulled forcibly outwards and somewhat upwards. Three long and strong harelip pins, somewhat curved towards the points, are next thrust through the substance of the tongue from the under surface of the anterior part of the organ as far back as its base. The chain being now hooked over the pins, the screw of the *écraseur* is set in motion, and the severance gradually and steadily effected.

Mr. Nunneley met with the most remarkable success from this procedure, since of 19 cases in which he removed the entire or greater portion of the tongue every one recovered, the patient requiring little after-treatment, and being usually able to go about within ten days. Mr. Fenwick, of Montreal, who has made some improvements in the operation, has resorted to it in three instances, with equally gratifying results; while the only fatal issue, with which I am acquainted, occurred to Mr. Gamgee, the patient perishing of hemorrhage.

The process of Nunneley has been modified by Paget, who, instead of piercing the parts under the chin, simply separates the tongue along the floor of the mouth with the knife, including the attachment of the *genio-hyo-glossal* muscles at the symphysis of the jaw. The tongue, thus liberated, is easily drawn forward, and brought under the control of the *écraseur*.

The principal dangers from ablation of the entire tongue are shock and hemorrhage, oedema of the glottis, pneumonia, pyemia, and erysipelas. The operation should always be performed with the aid of chloroform, and every possible care taken to secure even the smallest arteries. During the after-treatment, the head and shoulders should be kept well elevated, detergent and deodorizing gargles freely used, and leeches applied to the neck in the event of laryngeal involvement. Anodynes will be required to promote sleep and secure rest to the parts.

SECT. III.—AFFECTIONS OF THE SALIVARY GLANDS.

The salivary glands are not often the subjects of disease or accident. Their protected situation and the peculiarity of their functions are, doubtless, the chief causes of this immunity.

PAROTID GLAND.

The principal surgical affections of the parotid gland are inflammation, abscess, and certain tumors. Its excretory duct is occasionally the seat of earthy formations, of wounds, and fistules.

1. *Parotitis*.—Inflammation of this gland, as an idiopathic affection, is almost wholly confined to the young, constituting what is vulgarly called mumps. It is sometimes seen later in life, and in a few rare instances it is witnessed in elderly persons. It is more common in males than in females, generally prevails as an endemic, or epidemic, and, like most diseases of this class, seldom attacks the same individual more than once. It may occur at any period of the year, but winter and spring are its favorite seasons. Both glands usually suffer, although not always in an equal degree.

The disease commonly begins with some degree of stiffness in the temporo-maxillary articulation, which rapidly increases in severity, and thus materially interferes with mastication. The swelling is particularly conspicuous just in front of the ears, which are often seriously implicated in the morbid action, and is almost always attended with a good deal of pain and constitutional disturbance, without any local discoloration. In most cases, it extends down the neck and along the base of the jaw, imparting thus a singular expression to the features. As the inflammation progresses, the other salivary glands are apt to suffer; and, in the more aggravated forms of the disease, difficulty of deglutition is experienced, from involvement of the tonsils and arches of the palate. It usually reaches its height in about four days, when it begins to decline, and in a few days more terminates in resolution, rarely in suppuration or gangrene. A peculiarity of this variety of inflammation is its tendency to leave the organ primarily affected, and to fasten itself suddenly upon the testicle or mamma. How this transfer is established is wholly inexplicable by any known law of the animal economy, the more so as there is no connection either direct or indirect between these parts. It is most apt to occur in young men, at a period

varying from a few days to a week from the invasion of the malady. A violent parotitis, liable to terminate in abscess, and even in mortification, occasionally follows erysipelas, certain forms of fever, as typhoid and scarlet, and the abuse of mercury.

Mumps is generally not a dangerous disease, but it may become so when it extends to the brain and testicle; in the former case, it may destroy life, in the latter it may induce atrophy and loss of function of the affected organ. A number of examples of the latter termination have fallen under my observation. When both testes suffer, impotence may be the result.

Parotitis seldom requires much treatment. In general, it is easily managed by rest, light diet, aperients, and diaphoretics, with warm applications to the affected parts. Sometimes a warm cataplasm promptly relieves the pain and swelling; at other times, great benefit is experienced from the use of slightly stimulating embrocations, as soap, iodine, or volatile liniment, with a thick covering of raw cotton. Cold applications should be carefully avoided, on account of their repellent tendency. In violent attacks, recourse is had to the lancet, or, at all events, to leeches, active purgatives, and antimonials. If much gastric disturbance exist, along with pain in the back and limbs, a brisk emetic will be useful. When the testicle is threatened by a translation of the malady, a blister should at once be applied over the parotid, in order to reinvoke the inflammation. When the disease is fully established in the testicle, the usual antiphlogistic remedies are indicated, and should be employed without delay, lest structural lesion take place. Occasionally a good deal of hardness remains in the parotid region after the violence of the morbid action has disappeared. The proper way to meet this is to use stimulating embrocations and unguents, aided, in obstinate cases, by the constitutional effects of mercury.

2. *Abscess.*—Abscess of the parotid is nearly always of an acute character, the result of simple inflammation, local injury, erysipelas, typhoid fever, smallpox, and other eruptive affections. The presence of matter is indicated by discoloration of the skin, circumscribed swelling, and high constitutional disturbance. The parts pit on pressure, the pain is excessive, and the patient is unable to open his mouth. Sometimes the swelling is remarkably diffused, apparently from the involvement of the extensive venous network both of the gland itself and of the surrounding parts. The fluctuation is generally very obscure, on account of the manner in which the contents of the abscess are bound down by the cervical fascia and capsule of the gland. Owing to this circumstance, the true nature of the disease is apt to be overlooked, and the pus allowed to burrow about in different directions; thus producing the most serious mischief, opening, perhaps, after having induced the most violent suffering, into the auditory tube, or extending down the neck along the great vessels, and causing extensive havoc in the connecting cellular tissue. In some instances the fluid passes round the trachea, and finally destroys life by bursting into the chest. To prevent these disastrous effects, and to relieve the horrible pain which always attends the disease, an early and free incision should be made vertically into the most prominent, and also, if possible, into the most dependent, part of the swelling, and kept open by means of a tent, until the cavity of the abscess is in great measure obliterated. The system, meantime, must be properly supported by stimulants and anodynes.

3. *Gangrene.*—Mortification of this gland occurs chiefly in erysipelas, typhoid fever, scarlatina, and smallpox. Sometimes it follows upon violent salivation. Fortunately, however, it is very rare in any form of disease. The sloughing is usually most extensive in the connecting cellular tissue, but occasionally it affects the glandular substance also, which it may completely destroy, as I have had occasion to observe in several cases. In one of these not a vestige of the organ was left, its former site presenting a deep hollow, extending down to the ramus of the jaw and the auditory tube. When gangrene is impending, or has actually taken place, free incisions should be made, followed by the application of a yeast or port wine poultice, with the nitric acid lotion and appropriate constitutional means.

4. *Tumors.*—Morbid growths of a carcinomatous, cartilaginous, fibrous, cystic, myxomatous, sarcomatous, and fatty character, are sometimes developed in the parotid, or in the cellular and adipose tissue surrounding it. In many cases, possibly the majority, they appear to originate in the lymphatic glands imbedded in its substance, placed upon its outer or deep surface, or situated in its immediate vicinity. Pure forms of any tumor of the gland itself are uncommon, their power of combination being very great. Thus, we may have a lipomatous myxoma, or the converse;

combinations of fibromas with sarcomas, cystomas, and myxomas are not unfrequent; but the most common mixture is that with cartilage tissue, giving rise to lipomatous, myxomatous, fibrous, myxo-fibrous, sarcomatous, or myxo-carcinomatous enchondroma. The precise nature of the disease, whether circumscribed or involving the entire gland, can rarely be determined by outward inspection or manual examination, and hence the classification of parotid neoplasms was formerly, and is even now, greatly confused. Of 95 cases collected by Bruns, Billroth, and Weber, in which their character was determined by careful microscopic investigation, 28 were chondromas; 26 carcinomas, of which 9 were encephaloid, 10 epithelial, and 7 scirrhus; 20 fibro-myxo-chondromas; 6 fibromas; 5 cystomas; 4 melanotic adenosarcomas; 3 sarcomas; and 3 myxomas. Pure adenomas are either unknown, or are extremely rare, but hyperplasia of the glandular elements is observed in connection with enchondroma, sarcoma, and carcinoma. The fatty tumor is also very uncommon.

Parotid tumors are generally met with between the thirtieth and fortieth year; encephaloid, myxoma, and enchondroma being usually observed before the twentieth year; while fibromas and sarcomas are almost peculiar to young adults. Scirrhus and epithelioma are essentially affections of advanced life. They usually grow rather slowly, but they are almost always, even when of inconsiderable bulk, accompanied by anæsthesia, paralysis of the facial muscles, and severe pain, from their pressure on the adjacent nerves; the deformity is great, sometimes hideous, and the patient is eventually unable to masticate and open his mouth. In their volume they vary from a walnut to a fetal head. The largest are usually the medullary carcinomatous, sarcomatous, and myxomatous, the scirrhus, fibrous, and cystic rarely attaining much bulk. During their progress these tumors occasionally encroach so much upon the vessels of the neck as materially to diminish their caliber. Indeed, cases have been reported in which both the carotid artery and internal jugular vein were completely obliterated. The nerves are always more or less severely compressed, and the consequence is that the local suffering is generally very distressing, especially when the morbid growth is uncommonly large, firm, or deep-seated.

The cartilaginous, fibrous, cystic, and sarcomatous tumors are movable, rarely affect the skin, and are not accompanied by involvement of the neighboring lymphatic glands. The cartilaginous growth is distinguished by its distinctly lobulated surface, its dense consistence, remarkably tardy development, and occurrence in early life. Cystic tumors are diagnosed by their slow progress, small size, elastic feel, and increase in volume and tension during articulation and mastication. In doubtful cases the exploring needle will reveal the true nature of the growth. Fibrous, fatty, myxomatous, and sarcomatous tumors present the same features here as in other situations. The tendency of carcinomatous formations is to destroy life, either by constitutional contamination, or by ulceration and profuse discharge. They are characterized by their immobility, large volume, rapid development, great suffering, involvement of the skin, disposition to ulcerate, the formation of foul, bleeding, fungous masses, and implication of the tonsils and neighboring lymphatic glands. The softer forms, as encephaloid and medullary epithelioma, usually run their course with great rapidity, often causing death in eight, twelve, or fifteen months. Encephaloid is almost peculiar to young persons, has a pulpy or elastic feel, the subcutaneous veins are greatly enlarged, and there is an early disposition to fungous protrusion and contamination of the soft structures in its vicinity. The scirrhus form is most common in elderly subjects, and is distinguishable by its extraordinary hardness, by its tardy progress, and by its comparatively small bulk. The melanotic tumor is, in general, easily recognized by its peculiar complexion, by its lobulated surface, and by its march, which is intermediate between that of scirrhus and encephaloid. It appears at various periods of life; but is most common in young adults.

Many years ago I met with a rare case of lipomatous myxoma in a man, forty-two years of age. The tumor involved the right parotid gland, which had gradually increased in size, without pain or tenderness, until it was nearly three times the natural bulk. After the extirpation of the organ, it was found to be remarkably friable, of a pale bluish color, and quite greasy and gelatinous to the touch. The glandular texture was still recognizable, but the fibrous tissue was apparently completely metamorphosed. When pressed between the fingers, a clear, oily fluid oozed out, which, after the gland had been immersed for some time in alcohol, collected in considerable quantity upon the surface of the liquor. The patient

made an excellent recovery, but of the final issue of the case I am not informed. There were no symptoms by which the nature of the disease could be determined before the removal of the organ. The man sought relief on account of the bulk of the tumor, and the impediment it occasioned in the movements of the jaw.

5. *Extirpation*.—Considering the narrow space in which the parotid gland is situated, and the complexity of the relations which it sustains to the surrounding structures, is it possible to extirpate it in the living subject? This question, so interesting in every point of view, has not been answered alike by all writers. Allan Burns thought the operation impracticable, and a similar opinion has been strenuously advocated by other authorities. Notwithstanding this, however, it has, unquestionably, been repeatedly performed successfully, as every one familiar with the history of surgery well knows. Dr. Brainard, some years ago, analyzed ninety-one cases, including two by himself, in which he had every reason to believe that the entire gland was extirpated. On the other hand, of 167 cases collected by Professor Bruns, only 12 were instances of complete extirpation; in 46, the greater part of the gland was removed; while in 109, the operation was limited to partial extirpation. In view of these facts, it would be folly either to doubt the possibility of the operation, or to deny its propriety. That the operation is difficult of execution, requiring the most accurate knowledge of the anatomy of the parts, and the most consummate skill, is certain, and, unless the surgeon is fully possessed of these important qualities, failure, if not disgrace, will be sure to attend his efforts. It should be added, however, by way of encouragement, that it is much easier, in almost every instance, to remove a diseased than a healthy gland of this kind. In the former case, its fibrous envelop is usually so much condensed as to inclose and circumscribe the organ, rendering it thus perfectly distinct and separate; whereas, in the latter, it is a soft, ill-defined mass, which it is extremely difficult, even in the dead subject, to disengage from the surrounding structures by the most patient and cautious dissection.

In performing the operation, the patient lies upon a table, on the sound side of his face, with the head and shoulders well elevated. When the tumor is small, not exceeding the volume of an egg, a single incision, extending obliquely down in front of the ear, from a short distance above the zygomatic arch of the temporal bone, to within an inch below the angle of the jaw, will usually afford sufficient space for our purpose; but in all other cases it should be crucial, elliptical, or T-shaped. The form of the incision, however, is of little moment, provided it is large enough to admit of free access to the diseased mass. The flaps having been dissected up in the usual manner, the tumor may next be lifted from its bed, either from above downwards, or, what is better, from below upwards. Whichever plan be adopted, the utmost caution is necessary in liberating the deep-seated parts, on account of the danger of wounding the internal carotid artery and the jugular vein, with their accompanying nerves. In executing this step of the operation, more reliance should be placed upon the handle of the knife than upon its point, which can hardly be employed, in a situation so deep, narrow, and full of important structures, without the risk of injury. When the connecting tissues are unusually soft or brittle, the tumor may be partly wrenched from its bed with the fingers; but such a proceeding is always objectionable, inasmuch as it is liable to be followed by undue inflammation. The digastric muscle is frequently expanded over the tumor, and requires division.

The extirpation of this organ, for whatever object it may be undertaken, must necessarily be attended with loss of blood; but this is never, or, at least, rarely, very great, if the dislodgment of the gland be effected from below upwards, instead of in the opposite direction. By this procedure the external carotid will be exposed at an early stage of the dissection, and may, therefore, be readily commanded either by the finger or the ligature. I can see no reason for securing this vessel as a preliminary measure; for, in the first place, it is not always divided, and, in the second, the expedient is often impracticable on account of the great volume of the tumor. In the latter case, advantage might be derived from compression of the common carotid. When this vessel is much shrunk, from the pressure of the tumor, the chief source of the hemorrhage is the recurrent circulation.

The operation is always followed by paralysis of the corresponding side of the face, on account of the division of the motor branch of the seventh pair of nerves. The loss of power may last during life, or it may gradually disappear, at least in part. The resulting inflammation is generally severe, and requires the greatest vigilance in the management of the case. The patient may perish from the shock of the

operation, from loss of blood, or from inflammation of the throat and larynx. Recurrence of the disease may confidently be expected when the operation has been performed on account of a malignant growth, generally at a period varying from three to six months.

Extirpation of this gland was first performed in this country by Dr. Warren, of Boston, in 1798. To the late Dr. George McClellan, of this city, however, is due the credit of having generalized the operation. Of 11 cases in which he executed it, 10 recovered.

6. *Tumors over the Parotid.*—Tumors not unfrequently form in the connective tissue or in the lymphatic glands upon and around the parotid, which, acquiring a considerable bulk, and enlarging in different directions, choke and compress the proper substance of the organ, thus causing it to waste and shrink. Excision, under such circumstances, may induce the unwary to suppose that the parotid has been removed, when, in fact, the morbid growth was altogether of an adventitious character; and there is reason to believe that many, if not all, of the earlier operations in this region were of this description. These formations, however, as they do not differ from those of the gland itself, are liable to be mistaken for true parotid tumors, and it must be confessed that they are often with difficulty distinguished from circumscribed neoplasms, which involve only a few of the lobules or groups of lobules, and spring from the periphery, especially that small portion of the gland known as the accessory parotid, which occasionally exists as a separate lobe. When a tumor in front of the ear is freely movable from its very commencement, and is superficial to the parotid fascia, it may be assumed that it originated either in the subcutaneous connective tissue, or, more rarely, in a lymphatic gland; and this opinion will be converted into certainty if, after its extirpation, the elements normal to the gland are absent. When the parotid is protruded by, but not involved in, morbid growths which spring from the sphenomaxillary fossa or the upper wall of the pharynx, the distinction is not so easy; but the incision made for their removal exposes the glandular tissue which forms a partial investment for them, and thus clears up the diagnosis.

The most common of all tumors of this region are the *cartilaginous*, either pure, or, as more frequently happens, combined with other formations. Arising either in the connective tissue or in a lymphatic gland, they are distinguished by their slow and painless progress, their appearance at an early age, their lobulated outline, and their dense consistence. They occasionally acquire a large bulk, as in that removed by John Hunter, which weighed one hundred and forty-four ounces, and measured nine by seven inches. Large dimensions are also attained by the *myxomatous enchondroma*, of which I saw a striking example at the Clinic of the Jefferson Medical College, in 1866, in the hands of my colleague, Professor Pancoast, in a man, twenty-eight years of age. The tumor, which was of the size of a small goose-egg, and of an elongated, ovoidal shape, occupied the usual site of the parotid gland, and, although it had been gradually increasing for a number of years, had caused neither pain nor any other inconvenience. After excision, it was found to be of a light rose color, semitransparent, and deeply nodulated upon the surface. The patient made a good recovery; but of the final issue of the case I am uninformed.

The *glandular parotid* tumor, which bears a striking resemblance to the mammary glandular or adenoid tumor, is sometimes met with in this situation, where it gives rise to a distinctly circumscribed, firm, hard, elastic swelling, which grows slowly, rarely acquires considerable dimensions, and exhibits, on section, a lobulated appearance. Its structure is closely imitative of that of the parotid, consisting of acini and tubes filled with nucleated cells, and connected together by fibrous tissue. It is occasionally intermixed with cartilage and cysts; but from the predominance of true glandular tissue, which, however, is probably not of new formation, I am of the opinion that it arises either from the detached accessory portion of the gland or from a separated group of lobules, as is witnessed in the thyroid gland, and not from a lymphatic gland, a mode of development taught by some pathologists. In nearly all of the cases that I have examined, the growth was more or less closely connected with the parotid, a fact which also serves to point to its glandular origin.

Lymphatic glandular tumors, the result of hypertrophy from chronic inflammation or tubercular deposits, are sufficiently common in front of the ear, especially in young subjects of a scrofulous diathesis.

Cysts, filled with serous, sero-sanguinolent, or bloody fluid, are sometimes found here, perhaps partially imbedded in the parotid gland, and crossed by the branches

of the facial nerve, thus rendering their removal very difficult. Their contents occasionally consist of pure blood, either fluid or grumous, and interspersed with granular matter and crystals of cholesterine. Their walls are generally thin and polished, but in rare cases the inner surface exhibits a peculiar reticulated appearance, not unlike the right auricle of the heart. They may acquire a considerable bulk, and usually impart a distinct sense of fluctuation.

A few years ago, I removed from the parotid region of a gentleman, fifty-eight years of age, a *melanotic tumor*, of the size of a hen's egg, which required a very tedious dissection on account of its cystic structure, and its intimate relations with the surrounding parts. Its peculiar character was rendered evident prior to the operation by the blackish appearance of the skin.

In extirpating morbid growths in this region, care should be taken to guard against injury of the branches of the portio dura, and also of the duct of Steno, the integrity of which should never be disturbed in any case whatever. The operation should be conducted upon the same principles as in excision of the gland itself.

7. *Affections of the Duct of Steno.*—This canal occasionally suffers in wounds of the face. The proper treatment is to put the edges of the divided structures in their natural relations, and to maintain them thus by several points of the twisted suture, aided by perfect quietude of the cheek. The object is to effect accurate parallelism between the two ends of the divided tube, and, when this is done, there is little danger of any untoward occurrence.

Earthy concretions are now and then met with in this tube. They are generally of an ovoidal shape, of a whitish color, rough on the surface, and composed of phosphate and carbonate of lime in union with a little animal matter. After having lain dormant for an indefinite period, their presence finally awakens severe pain, and sometimes even a great deal of constitutional excitement. In a case that was under my charge several years ago, in a man, aged thirty-nine, there was excessive swelling of the cheek, with a ridge-like elevation in the course of the excretory tube, and a diffused, erysipelatous discoloration of the skin. The parts were very hard and tender, the jaw was moved with extreme difficulty, and there was high inflammatory fever. Being satisfied that there must be a salivary calculus, I made a free incision into the orifice of the distended duct, on the inside of the mouth, but nothing followed, except a small quantity of a whitish, glutinous substance, intermixed with a few drops of pus. The concretion did not escape until the next day. The pain and swelling rapidly subsided, but for nearly six months the canal continued to be greatly distended, in consequence of the partial closure of its orifice, which required occasional puncture and dilatation to effect a permanent cure. When the inflammation caused by the foreign body is very severe, leeches, cataplasms, purgatives, and other antiphlogistic means are indicated. Extrusion is effected, as soon as the diagnosis is established, by a free incision into the duct, on the inside of the mouth. Sometimes the calculus projects at the orifice of the canal, and then the forceps take the place of the knife.

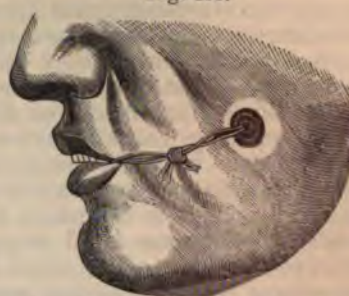
A *fistule* of the duct of Steno is often a very grievous affair, and may be caused by wound, ulceration, abscess, or gangrene. Some of the very worst forms of the lesion that I have ever witnessed were produced by sloughing from pytalism. Such an occurrence is always to be deplored, inasmuch as it often involves great deformity of the features, and irremediable chasms in the soft substance. A fistule of this duct is not only unseemly and inconvenient, but it is attended with the loss of a fluid that plays an important part in the animal economy.

The principles of treatment are very simple, for they consist merely in changing the direction of the abnormal orifice, and in closing the fissure in the cheek. When the occurrence depends upon a recent wound, all that is, in general, required is the use of the twisted suture, and a compressing bandage; but if some time has elapsed, it may be necessary, in addition, and as a preliminary step, to pare the edges of the opening, in order to place them in a condition favorable to the adhesive process. In fistule caused by abscess, ulceration, or suppuration, a cure may sometimes be effected by cauterizing the parts with nitrate of silver, acid nitrate of mercury, or a heated probe. A slight eschar is thus formed, and, granulations subsequently springing up, the saliva gradually resumes its natural channel. In the more obstinate forms of the affection, the plan suggested by the late Dr. Horner may be adopted, as holding out a fair prospect of success. It is both simple and easy of

execution. The external orifice having previously been elongated a little in the direction of the zygomatic muscle, the head is supported upon the breast of an assistant, and a broad wooden spatula is introduced into the mouth, opposite to the site of the fistule. With a large, sharp saddler's punch the whole of the diseased structures, tube and all, is then removed, when the opening in the integument is immediately closed with the twisted suture. Cold water-dressing is applied until the completion of the union, which usually happens in a few days.

Sometimes a good cure may be effected with a seton, consisting of a thick, well-waxed silk cord, passed through the fistule, brought out at the corner of the mouth, and tied upon the cheek, as in fig. 400. The treatment is particularly applicable to those cases in which the inner orifice of the fistule is nearly obliterated. When the opening has been reëstablished, the seton is withdrawn, and the orifice in the skin closed by suture. When the fistule is very large and obstinate, as when it depends upon a loss of substance, autoplasty may become necessary.

Fig. 400.



Seton for the Cure of Salivary Fistule.

SUBMAXILLARY GLAND.

The submaxillary gland, from its protected position, and the manner in which it is isolated by the cervical fascia, is seldom the subject of disease. Of the malignant affections, to which, in common with the parotid, it is liable, *scirrhus* is the most frequent, although it is in reality extremely rare. The few cases in which it has hitherto been observed occurred in elderly persons, rather as a secondary than as a primary malady. In carcinoma of the lower lip and tongue, in malignant disease of the parotid, and in medullary lymphoma of the neck, it occasionally becomes involved during the progress of the original disease, or after this has been removed by operation. Sometimes the gland is enlarged and indurated from interstitial deposits, caused by the irritation of a tooth, carcinoma of the tongue, or disease of the surrounding lymphatic glands; but such an affection is very different from true *scirrhus*, and generally subsides with the cessation of the exciting influence.

Scirrhus usually begins in the form of a small, hard tumor, which gradually increases in size until it acquires the bulk of a hen's egg, or even of a large orange. It is slow in its progress, has an irregular surface, and is the seat of a constant darting, pricking, or lancinating pain. In time, the adjacent lymphatic glands enlarge, the organ contracts firm adhesions, the integument ulcerates, and the general health declines, as in *scirrhus* in other parts. When the tumor encroaches upon the mouth, it interferes with speech and mastication, if not also with deglutition.

As the diagnosis between this affection, and simple enlargement of the gland cannot always be certainly established, sound judgment imperatively dictates the propriety of a thorough investigation of the case, and the removal, if possible, of all sources of irritation, before we resort to so serious an undertaking as an operation. If the enlargement and induration are the result of ordinary causes, the mildest measures will often be sufficient to effect a cure, after attention to this circumstance. The removal of a carious tooth, or a dead piece of jaw-bone, with a few doses of aperient medicine, will generally enable the gland promptly to regain its original characters. When the malady is malignant, excision alone promises any relief, but this, unfortunately, is seldom permanent. The operation necessarily involves the facial artery, and, therefore, requires some degree of dexterity. One incision, extended horizontally over the centre of the tumor, in the direction of the lower jaw, will generally suffice. The facial artery will usually be found at the posterior part of the diseased mass, and should always be tied before it is divided. By this procedure the operation is rendered almost bloodless. The sublingual artery and the hypoglossal nerve must be carefully avoided. In separating the gland from its deep connections, the finger and handle of the knife will afford good service. When

the tumor is uncommonly large, the horizontal incision is intersected by a vertical one, the two representing the lines of the letter T.

Ordinary tumors, as enlarged *lymphatic glands*, occasionally require removal from this region. In general, they yield to antistrumous remedies and a properly regulated regimen; but when they resist these measures, and give rise to serious symptoms, nothing short of excision will avail. Such an operation is usually sufficiently simple, requiring less skill on the part of the surgeon than anatomical knowledge. Sometimes the tumor is immovably fixed in its situation, and then, if it be of large size, a tedious and careful dissection becomes necessary. The course which I generally adopt is to make a horizontal incision along the base of the jaw, an assistant holding the facial artery out of the way with a blunt hook. In an operation of this kind, a few years ago, the vessel escaped the knife, but secondary hemorrhage ensued after the application of the dressings, apparently from one of the nutrient branches of the submaxillary gland. This was readily secured, and the patient soon recovered.

A *cystic tumor* is occasionally met with in the submaxillary gland. The most remarkable example that I have ever seen occurred in a middle-aged, married lady, the mother of several children. It had made its appearance seventeen years previously, and was somewhat larger than a hen's egg, soft, fluctuating, free from pain, and unaccompanied by any enlargement of the subcutaneous veins. Upon being punctured, a thick, viscid fluid escaped, rendering it highly probable that it consisted merely of altered saliva. The patient was unwilling to submit to an operation, otherwise I should have evacuated the contents of the cyst, and injected it with a weak solution of iodine.

Enchondroma of this gland is even more common than of the parotid. Interesting cases of it have been recorded by Virchow and Scholz. The tumor, which may attain a considerable bulk, is characterized by its great firmness, by its tardy development, by its lobulated outline, and by the absence of constitutional involvement. It is liable to be mistaken for fibroid disease, but as the operation for its removal is similar, an error is of no material consequence.

The excretory duct of the submaxillary gland, like that of the parotid, is not unfrequently the seat of *calcareous concretions*. They occur in both sexes, chiefly in middle-aged and elderly subjects, although the young are not wholly exempt from them. Occasionally, indeed, they are congenital, as in an interesting case observed by Dr. Burdel, of Vierzon. Their composition is phosphate and carbonate of lime, cemented together by a small quantity of animal matter. A

Fig. 401.



Salivary Calculus.

calculus of this description of the left submaxillary gland, removed from a young man, is sketched in fig. 401. It was of a pyriform shape, rough, of a whitish color, and upwards of one inch in length. Its presence was productive of great pain and swelling at the side of the tongue, attended, for several weeks, with inability to masticate, and excessive difficulty of swallowing. The diagnosis of the case was perplexingly obscure, until the concretion protruded at the orifice of the duct, from

which it was finally withdrawn with the thumb and finger. Dr. Charles Carter, of this city, has kindly presented to me a salivary calculus, weighing fully one ounce, expelled by a lady, seventy-four years of age, in a violent paroxysm of coughing.

SUBLINGUAL GLAND.

The principal disease of the sublingual gland is *ranula*, a peculiar form of tumor caused by obstruction of its excretory ducts, and the retention of its peculiar secretion. The swelling seldom exceeds the volume of a pigeon's egg; but it may be so large as to encroach seriously upon the surrounding parts, impeding articulation and deglutition, pushing the tongue against the roof of the mouth, displacing the teeth, and bulging out underneath the chin. It has a grayish, translucent aspect, like the belly of a frog, whence its name; is of an irregular oval shape, and contains a glairy, ropy fluid, like the white of eggs. Sometimes the contents are thin and watery, sometimes thick and pultaceous, and sometimes, again, of a yellowish, oily nature, similar to the synovial liquor of the joints. Particles of gritty matter, probably a mixture of phosphate and carbonate of lime, are occasionally interspersed through them.

Most of the cases of ranula that I have seen occurred in young subjects between the ages of eighteen and thirty. The disease, however, is not peculiar to this period of life. Dr. J. A. Temple, of Toronto, has reported an instance in which it was congenital. It is generally slow in its march, causes little or no suffering, and is unaccompanied by derangement of the general health. These circumstances, together with its singular appearance, and its situation beneath and by the side of the tongue, always serve to distinguish it from other affections. The croaking state of the voice is observed only in cases of long standing and large bulk, and, as it is liable to attend other diseases of the mouth, is of no diagnostic value. When any doubt exists, it may be promptly dispelled by the introduction of the exploring needle.

It is not difficult to conceive how ranula is produced. It is essentially an encysted tumor. The orifices of the excretory canals of the glands being closed, either by direct adhesion, or by the interposition of some adventitious substance, the proper secretion, instead of passing off as fast as it is furnished, accumulates in the interior of the organ, causing, by its pressure, the absorption of a considerable portion of its substance, and thus forming a tumor which possesses all the properties just assigned to it. The retained fluid itself, as has been seen, undergoes most important changes.

The treatment of ranula must depend upon circumstances, as the age and volume of the tumor. In recent cases, it has been proposed to afford relief by removing the obstruction with a probe, frequently introduced into the orifices of the affected ducts; but all such attempts, if not futile, are exceedingly tedious and uncertain, and hardly worthy of trial. In my own hands, the most satisfactory results have uniformly attended excision of a portion of the sac, in the form of an oval flap, with a hook and a pair of scissors, the surface being well mopped with tincture of iodine. The wound soon suppurates, and gradually heals by the granulating process. Some surgeons rely upon the seton, while others place implicit confidence in injections of tincture of iodine, on the same principle as in hydrocele. Both methods are feasible, and usually effective. When the ranula is very bulky, or transformed into a solid, gristly mass, extirpation will be necessary, and it is well to know that the operation is, in general, neither difficult nor dangerous. A few years ago, I dissected out a growth of this kind, fully as large as a hen's egg, from the mouth of a young lady, who had long been the subject of paraplegia and dyspepsia. It was quite hard and solid, of a pale-yellowish color, not unlike a mass of fat, and was productive of no other inconvenience than what resulted from its bulk. Making a longitudinal incision along the side of the tongue, the flaps of mucous membrane were reflected to each side, when the tumor was easily enucleated with the handle of the scalpel. The parts speedily healed, and there was no return of the disease.

The sublingual gland is liable, although very rarely, to *calculous* formations. I have seen only one specimen of the kind, which I removed from a man fifty-four years old, after it had caused, for several weeks, severe local distress, attended with great difficulty in moving the tongue. Paré met with a case of ranula in which there were five of these concretions, the largest of which was of the size of an almond. The irritation occasioned by their presence had produced an immense abscess under the tongue.

Carcinoma of this gland, possessing all the characteristic features of this disease as it occurs in other parts of the body, is occasionally observed. The affection is very uncommon, and I have seen only two cases of it. The patient in one was a laborer, fifty-six years old, who had always been in good health up to May, 1858, when he noticed a swelling on each side of the middle line, just below the tongue. When he came to the College Clinic in the following November, the tumors were excessively hard, and of the size of a small

Fig. 402.



Scirrhous of the Sublingual Gland; Minute Structure.
X 472 Diameters.

almond; the pain was of a sharp, shooting character, and the movements of the tongue were much restrained. Excision being effected, a portion of the growth was subjected to microscopic inspection by Dr. Packard, who kindly furnished me with the annexed sketch, fig. 402, of its minute structure. The disease reappeared in three weeks, and gradually extended to the gums and jaw, forming a large tumor, exhibiting all the external marks of scirrhus. The glands along the base of the jaw were enlarged, and the general health was becoming rapidly undermined. In the other case, sent to me by Dr. Hermann Fritsch, of this city, the patient, sixty-three years old, had a hard, red tumor in the right sublingual gland, the size of a pullet's egg, which had been first noticed six weeks previously as a small lump. It was the seat of sharp, lancinating pains, and was attended with marked enlargement of the lymphatic glands at the base of the jaw. The man died, completely exhausted, in less than three months from the invasion of the disease.

SECT. IV.—AFFECTIONS OF THE FLOOR OF THE MOUTH.

There are certain affections in this situation which, manifesting themselves, for the most part, in the form of morbid growths, are often distinguished with difficulty from ranula and tumors on the under surface of the tongue. Fortunately these productions are uncommon. They consist chiefly of different kinds of tumors, more especially the fatty, cystic, and dermoid, the latter of which are generally congenital.

Of the *fatty* tumor I have seen only one instance. It lay underneath the free portion of the tongue, immediately under cover of the mucous membrane, and was of an elongated, ovoidal shape, tolerably firm in its consistence, and about the volume of a pullet's egg. It was free from pain, but interfered somewhat with mastication and articulation by its bulk and situation. The patient was a lady, thirty-seven years of age, for the last fifteen of which she had been affected in this manner. The tumor, after an incision carried along its upper surface, was easily enucleated with the finger and handle of the scalpel, and exhibited all the features of fatty tissue. The hemorrhage was insignificant. Similar cases have been observed by Dupuytren, Liston, Paget, and others.

Cystic tumors, containing a whitish, glairy, or serous fluid, are occasionally met with in this situation, apart from the sublingual gland, the formation of which may be traced to three sources. Some evidently consist of enlarged mucous follicles, caused by obstruction of their orifices, and are identical in character with the cystic tumor so frequently seen on the lower lip. They rarely exceed the volume of a hazelnut. Others are merely cysts of new formation, seated in the submucous connective tissue; while the third group is dependent upon enlargement of the mucous bursae attached to the outer surface of the genio-hyo-glossal muscles, and first described by Fleischmann, of Erlangen. These tumors contain a clear, serous fluid, and are not only projected under the tongue, but extend down into the neck under the sterno-mastoid muscle. The treatment of these various forms of sublingual cystic tumor is conducted upon the same principle as in ranula, with which they are liable to be confounded.

The *dermoid cystic* tumor of the floor of the mouth is generally, if not invariably, congenital. Commonly situated at the side of the middle line, it presents itself originally as a small tubercle of an opaque appearance and semisolid consistence, which gradually increases in size until at length it seriously encroaches upon the mouth, throwing the tongue backwards towards the throat and palate, and thus causing great impediment in mastication, deglutition, and articulation. The contents are essentially of a sebaceous character, often rolled up into little balls by the action of the muscles, and occasionally intermixed with hairs, similar to those found in sebaceous tumors of the forehead and eyebrows. How this variety of cystic growth is formed is still a mooted question. The best remedy is excision, although a cure may occasionally be effected with the seton or injections with tincture of iodine.

Gosselin, in a cystic tumor occupying the floor of the mouth, found the cyst-walls, on microscopic examination, to be *hydatid*, containing a number of hooklets. The growth was supposed, prior to extirpation, to be an ordinary ranula, so closely did it resemble a tumor of this kind.

SECT. V.—AFFECTIONS OF THE PALATE.

The principal surgical affections of the palate are wounds, inflammation, ulceration, and congenital deficiencies, analogous to those of the upper lip.

1. *Wounds*.—Wounds of the palate, both hard and soft, may be incised, lacerated, punctured, or gunshot, and usually exhibit the same phenomena as similar lesions in other parts of the body. Considerable hemorrhage is sometimes present, but this commonly ceases of its own accord, or is easily arrested by astringent lotions. When there is no loss of substance, and, consequently, little or no gaping, mere rest of the palate for a few days will generally be sufficient to effect a cure; when the reverse is the case, the interrupted suture may be necessary, the principle on which it is introduced being the same as in the operation for cleft palate described below.

The hemorrhage attendant upon wounds of the hard palate is sometimes very troublesome, especially when it proceeds from one of its main arteries. The only way of arresting it, promptly and successfully, is to expose the bleeding extremities thoroughly with the knife, and then ligating them; or, if this be impracticable, applying the actual cautery.

2. *Inflammation*.—Inflammation of the soft palate is usually associated with inflammation of the uvula and tonsils; it may be common or specific, and the treatment, consequently, must be modified according to the nature of the complaint. In the ordinary form of the disease, the principal remedies are purgatives, leeches to the neck, astringent gargles, and the application of nitrate of silver; in the specific, these remedies are conjoined with constitutional treatment, embracing the milder preparations of mercury, and the iodide of potassium.

3. *Abscess*.—Abscess of the soft palate is not uncommon, and may exist by itself or in union with suppuration of the tonsils. Indeed, there is reason to believe that the former is often mistaken for the latter, owing to the intimate connection of the two organs, and the fact that inflammation of the one is extremely prone to extend to the other. The treatment is the same as in tonsillitis, an early and free incision being made to let out the matter.

4. *Ulceration*.—Ulceration of the palate is generally dependent upon a syphilitic taint of the system. The sores, at first superficial, often extend through the entire thickness of the curtain and arches of the palate, and usually exhibit a foul, unhealthy aspect, with a copper-colored appearance of the surrounding surface. The breath is fetid, the patient is obliged to clear his throat frequently of inspissated mucus, and there is derangement of the general health, with, perhaps, syphilitic eruptions of the skin, iritis, and other evidences of constitutional contamination. The diagnosis is determined mainly by the history of the case, and by the peculiar features of the ulcerative process. The treatment is decidedly constitutional, aided, if the patient is robust, by venesection and leeching. Excitement having been subdued, a mild course of mercury is instituted, and the sores are effectually touched once a day with dilute acid nitrate of mercury, nitrate of silver, or sulphate of copper.

The hard palate may suffer in the same manner as the soft. The worst form of ulcer usually met with occurs in children and young persons, as the result of a strumous, syphilitic, or mercurio-syphilitic taint of the system. The patient looks pale and sickly, and the disease manifests an obstinate disposition to spread, sparing neither mucous membrane, fibrous structure, nor bone, which are often destroyed to a most serious extent. The mischief thus produced can frequently be repaired only by artificial means.

Occasionally syphilitic gummata occur here, as the result of a constitutional vice, in the form of small, hard, rounded, semielastic, multiple, and rather flattish masses, projecting very little beyond the surrounding level. By degrees, softening takes place, and the matter, which is of a peculiar gummy, starch-like character, finds an outlet, leaving an ulcer with a foul base and irregular edges, difficult to heal. The diagnosis in the earlier stage of the disease rests on the history of the case, the copper-colored hue of the mucous membrane, and the peculiar character of the tumors above described. The treatment is antisyphilitic.

5. *Tumors*.—Solid, semisolid, and cystic tumors are liable to form in the palate, both soft and hard, and may acquire such a bulk as seriously to impede mastication, deglutition, and respiration. Perhaps the most common of these tumors is the ade-

noid, or *adenoma*, an affection usually of early and middle life, having its seat in the mucous follicles of the hard palate, although a few instances have been met with in which it occupied the soft structures. The tumor is generally round or somewhat ovoid, distinctly circumscribed, of a firm, elastic consistence, tardy in its development, painless or nearly so, and free from malignancy, liable, however, to return, especially if not thoroughly extirpated. The only diseases with which adenoma of the palate is likely to be confounded are epithelioma and syphilitic gumma. From the former it may generally be easily distinguished by its tardy development, its regular outline, and its uniform consistence; from the latter, by the fact that it always exists as a solitary tumor, whereas the syphilitic affection is commonly multiple. The history of the case, too, will furnish important information.

A lad, eight years old, was brought to the College Clinic, in 1865, on account of an adenoma of the arch of the palate, hanging down into the fauces, and thus interfering very considerably with respiration, deglutition, and articulation, the voice having a peculiar muffled expression. It was of a firm consistence, of a grayish color, and about the volume of a small walnut. The history of the case showed that it had grown rapidly. Fearing that excision might give rise to serious hemorrhage, I twisted the tumor off with a double canula armed with a stout silver wire, the operation being followed by a complete cure.

Instead of forming a prominent, circumscribed tumor, adenoma of the arch of the palate may be multiple and diffused, giving rise to general hypertrophy of the part. In a case of this description, referred to by Cornil and Ranvier, the glands were so much enlarged as to increase the thickness of the velum of the palate to four-fifths of an inch.

Malignant disease may occur here in two varieties of form, the epithelial and encephaloid. The former is easily diagnosed by the irregularity of its shape, its tuberculated surface, its fetid discharge, and its slow but steady progress; the latter, by its circumscribed form, its rapid development, and its smooth outline, followed, when ulceration takes place, by the fungoid and bleeding character of the sore. In both cases there will, sooner or later, be marked involvement of the lymphatic glands at the base of the jaw.

Cystic tumors, due to obstruction of the mucous follicles, are occasionally met with in the soft palate, where they may attain the volume of a hen's egg. Dr. Cabot, of Boston, has described a tumor, probably a cystic adenoma, which he removed from the hard palate. It was of a roundish shape, of a yellowish-white color, nearly smooth, somewhat tender on pressure, and of eighteen months' duration. It had a distinct capsule, and in one part of it a warty appearance. Denticulous cysts of the hard palate have occasionally been observed.

The proper treatment of these various formations is early excision, and the procedure will be greatly facilitated if the tumor, when it occupies the soft palate, be previously seized and drawn forwards with a volsella, or stout hook. No serious apprehension need be entertained respecting hemorrhage, as no large vessels are in the way; should it prove troublesome, recourse must be had to styptics, and, if necessary, to the actual cautery. The treatment of the cystic tumor consists in the injection of iodine, or the application of nitrate of silver to the interior of the sac, previously exposed by a free incision.

The *vascular erectile* tumor of the vault of the palate is uncommon. It usually shows itself as a soft, reddish, bluish, or livid growth, from the size of a pigeon's egg to that of a walnut, of a rounded shape, smooth on the surface, and pulsating synchronously with the heart, especially when it is of a strongly arterial character. When it is composed chiefly of a network of veins, there is generally an absence of pulsation, and, in that event, the tumor is also much darker. Sometimes the tumor ulcerates, especially when it has attained a large bulk, and a case has been recorded in which it was subject to periodical hemorrhages, apparently vicarious of the menses.

The diagnosis of such a growth is commonly very easy. The history of the case, the absence of pain, and the peculiar color of the tumor always serve to distinguish it from abscess, almost the only affection with which it is liable to be confounded.

If the tumor be purely venous, the most appropriate remedy will be excision; if arterial, ligation or the actual cautery. When the growth is of the latter description, and of large bulk, almost filling the roof of the mouth, any operation intended

for its relief will be likely to prove extremely formidable, and should, therefore, not be undertaken without due precaution.

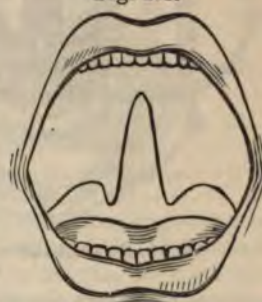
Of *aneurism* of the vault of the palate I saw a very interesting case in 1849, in a young army officer who had been accidentally stabbed with a small knife upwards of two months previously, the blade opening the superior palatine artery on the right side. The tumor, which was of a spherical shape, and about the volume of a marrow-fat pea, pulsated synchronously with the heart, and was of a soft, spongy consistence, readily yielding under pressure. A cure was promptly effected by laying open the tumor, and tying the artery at both ends. The only other case of this rare disease of which I have any knowledge, occurred to Teirling, who effected a cure with the actual cautery.

A rare case of *papillary fibroma* of the mucous membrane of the hard palate, of the size of a split chestnut, and covered with papillæ the eighth of an inch long, has been reported by Mr. Salter. The proper remedy is excision.

Cartilaginous, osseous, and sarcomatous tumors of the hard palate have occasionally been described. Whether central, or peripheral, they do not differ from similar formations of other portions of the upper jaw, and do not require special description.

6. *Cleft Palate—Staphylorrhaphy—Velosynthesis.*—The palate is subject to congenital deficiency, analogous to harelip and bifid spine, with which, especially the former, it not unfrequently coexists. The defect occurs in various degrees, being sometimes very trifling, at other times exceedingly great. In the most simple form, which is, however, not the most common, it presents itself as a small, triangular fissure, illustrated in fig. 403, extending through the uvula and the posterior portion of the velum, the remainder of the palate being perfectly natural. Sometimes, indeed, the uvula alone is affected. In a second series of cases, the cleft involves the whole of the soft palate, or this structure and, perhaps, a part of the palate bone. In a third variety of form, both the soft and hard parts are deficient, the slit reaching from one end of the palate to the other. Fourthly, the cleft is occasionally associated with a cleft in the alveolar process of the maxillary bone, on one or both sides, and even with harelip. Finally, cases occur, although rarely, in which the hard palate alone is implicated.

Fig. 403.



Cleft Palate.

The width of the gap, like its length, is subject to considerable diversity. Thus, it may not exceed a few lines, or it may be so great as to constitute a hopeless deformity. When it is limited to the soft palate, it is always of a triangular shape, the base being below, the apex above. When it involves both the soft structure and the roof of the mouth, it is generally of an oblong quadrilateral figure, the nasal septum extending along its centre, and dividing it, as it were, into two equal parts. The edges of the fissure, whatever may be its size and form, are always rounded off, and of a firm, fibrous consistence, being often pared with much difficulty.

The effect of this condition of the palate, during infancy, is interference with suction and deglutition, and afterwards with mastication and articulation. The degree of the impediment is generally in proportion to the extent of the cleft. In the more severe forms, much of the food passes into the nose, where, causing irritation, it excites sneezing, inflammation, and even ulceration. From the imperfect control which such persons have over the muscles of the palate, both fluids and solids are very liable to descend into the windpipe. The speech is guttural and nasal, and frequently so indistinct as to render it, in great degree, unintelligible.

When the case is one suitable for surgical interference, the first thing to be done is to subject the patient to a course of preliminary training, to enable him to bear the necessary manipulations. With this view, the palate is frequently touched with the finger, or rubbed with a tooth brush, probe, or spoon, until it no longer resents the contact of the foreign body, but is perfectly calm and quiet under the most protracted exercise. This treatment may occupy several weeks, or even a longer time, depending upon the irritability of the parts, and the courage of the patient. Another point, equally necessary, is the coöperation of the patient, without which success will be entirely out of the question. I have occasionally performed staphylorrhaphy before the twelfth year, but, in general, it is better to postpone it until a

later period, and even then it should not be undertaken unless it is pretty certain that the individual will be entirely passive during the perplexing and fatiguing ordeal to which he is obliged to submit. It is hardly necessary to add that, at the time of the operation, he should be perfectly well and free from cough.

Mr. Thomas Smith, of London, has recently, with the aid of a suitable gag, performed the operation in early childhood; and others have demonstrated its feasibility with the aid of chloroform.

The operation, technically called *staphylorrhaphy*, may be considered as consisting of three stages. In the first, the edges of the fissure are pared, in the second, the sutures are introduced, and, in the last, the ligatures are tied.

The patient sitting upon a chair with a firm back, his head is supported upon the breast of an assistant, and held in such a manner as to allow the light to fall in a

full stream upon the palate. The jaws being widely separated, and the tongue duly depressed, either by the patient's own efforts, or by another assistant, or, what answers still better, the gag of Dr. Whitehead, of New York, represented in fig. 404, the first stage of the operation is begun. The most suitable instruments, according to my experience, for seizing and paring the parts, are a pair of long, slender forceps, and a knife similar to Beer's cataract knife, only much longer in the handle. If the fissure is very wide, as little of the edges should be removed as possible; when the reverse is the case, a piece not less than a line in breadth is sliced off on each side. The knife is entered at the upper angle of the cleft, and drawn steadily downwards until it cuts itself out below. The process is then repeated on the opposite margin, the forceps being employed, meanwhile, for

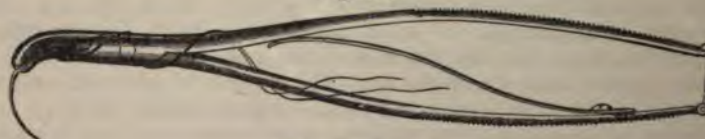


Whitehead's Gag and Tongue Depressor.

putting the parts gently on the stretch. Some bleeding necessarily attends this stage of the operation, but this is commonly over in a few minutes, and should never be treated with astringents, as they have a tendency to impair adhesive action. A brief respite is now afforded, that the patient may recover from his fatigue, and regain his self-possession, which, although this part of the operation is neither painful nor protracted, is often severely tried.

The second stage of the procedure consists in introducing the sutures, of which three, placed equidistant from each other, are generally sufficient. If the refreshing of the edges of the fissure is troublesome, the arrangement of the suture is still more so. Indeed, it is the most difficult part of the whole procedure. It is executed with a needle, of the size and shape represented in fig. 405, armed with well

Fig. 405.



The Author's Forceps.

waxed silk thread, or, what is far preferable, silver wire, and held in the jaws of a pair of forceps, constructed for that purpose. The one which I am in the habit of using is here delineated, and is an unexceptionable instrument. The spiral needle, seen in fig. 406, is also well adapted to the object. In using it the operator stands behind the patient, and passes the stitches from right to left. The first suture is introduced at the inferior extremity of the cleft, the needle being carried across from left to right, entering and issuing nearly a sixth of an inch from the raw

margin. The next suture is applied near the middle of the gap, and the third within a few lines of the superior angle. During their introduction, the palate is rendered

Fig. 406.



Spiral Needle.

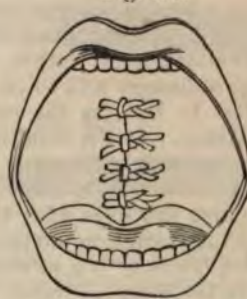
somewhat tense by grasping the uvula with a pair of forceps, and, as soon as the needle has transfixed the parts, it is seized at its point, drawn out and reinserted into the instrument. The ends of each ligature are brought out at the corners of the mouth, where they are held by an assistant. When the patient is sufficiently docile, this stage of the operation is neither fatiguing, protracted, nor painful. The arrangement of the ligatures is exhibited in fig. 407.

Fig. 407.



Situation of the Sutures in Staphylorraphy.

Fig. 408.



Mode of Tying the Sutures.

All that now remains to be done is to fasten the sutures, and this is, undoubtedly, one of the most delicate steps of the whole procedure. Taking hold of the long ends of the inferior thread, as they lie at the corners of the mouth, they are tied into a reef-knot, and cut off within a line of its surface. The other sutures are then secured successively in the same manner, the upper one being always tied last. These appearances are exhibited in fig. 408. If the ligatures have been well waxed previously to their introduction, they may generally be easily tied with the fingers alone; but, when this precaution has been neglected, or the gap is inordinately wide, the loop may slip unless held with the forceps until the knot is completed. If the wire be used, the ends may be fastened by torsion or with small shot. The same rules are applicable here in regard to the approximation of the edges of the fissure as in harelip; care being taken, on the one hand, that it is not too close, and, on the other, that it is not too slight.

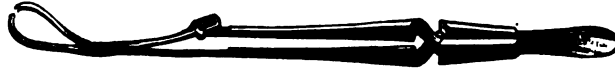
In paring the edges of the fissure, as well as in the subsequent steps of the operation, the sponge mop generally affords useful aid in clearing away blood and mucus. At least four such instruments should be at hand in every undertaking of the kind.

In most of the operations performed for the cure of this defect, it is necessary, as suggested by Dr. J. Mason Warren and Sir William Fergusson, to divide the palato-pharyngeal and elevator muscles, on account of the resistance which they offer to the approximation of the edges of the fissure. When the chasm is unusually large, or the irritability of the palate very great, this should always be done immediately after the process of abrasion; but, under opposite circumstances, it may be advantageously postponed until the stitching has been done, and, in the more simple forms of the affection, it may, as I know from experience, be very properly omitted altogether. The division of the palato-pharyngeal muscle is easily effected, as originally practiced by Dr. Warren, by cutting, with stout, curved scissors, through the posterior pillars of the palate, immediately below the tonsil, the parts being previously put on the stretch with the forceps delineated in fig. 409; while the elevator muscle is best reached by the process of Mr. Pollock, in which a narrow, sharp-pointed knife is passed upwards and backwards through the palate, a little in front and to the inner side of the hamular process. The handle of the knife being now

raised, thereby depressing its point, thorough division is insured during its withdrawal by making a sweeping cut downwards.

When the uvula is abnormally long, it may be advantageously retrenched at the close of the operation; and occasionally I have found it convenient to stitch the opposite halves together, in order to insure their more accurate adhesion.

Fig. 409.



Forceps for Staphylorraphy.

The operation being over, the patient sits up, or lies down, as may be most agreeable, absolute recumbency being rarely necessary. The great point is to keep the parts perfectly at rest; hence, talking, laughing, hawking, spitting, coughing, sneezing, and even opening the mouth widely, are to be most carefully avoided. The diet must be perfectly bland and simple, yet sufficiently nourishing, consisting entirely, until the adhesive process is well advanced, of custard, boiled bread and milk, animal broths, milk porridge, and similar articles, with iced water, lemonade, or tea, carefully swallowed, or, rather, allowed to trickle down the throat, as often as the cravings of hunger and thirst may demand. In a word, the patient must be well fed, from first to last, as the success of the operation will greatly depend upon this circumstance. If the resulting inflammation is very severe, blood is taken from the arm, or by leeches from the base of the jaw, and the bowels are freely opened by enemata. The tough, adherent mucus around the line of the wound, so annoying for the first few days after the operation, is removed, from time to time, with a soft mop, and its secretion moderated by touching the affected surface every eight, ten, or twelve hours with a solution of nitrate of silver, in the proportion of two to five grains to the ounce of water. The sutures are not disturbed so long as they appear to do good; generally they are not removed before the eighth day, and the inferior one often not until twenty-four hours later. If the union is imperfect, as evinced by the gaping between the sutures, either additional stitches are employed, or an attempt is made to effect closure by the gentle application of nitrate of silver. If it

fail entirely, the operation is repeated, time being afforded the parts to recover from the shock and irritation of the first effort. Occasionally a small gap, as in fig. 410, remains at the upper angle of the wound, which nothing can close.

The acquisition of the power of speech after staphylorraphy is generally very slow; a circumstance of which the patient and his friends should be fully apprised beforehand, otherwise it may lead to sad disappointment and even reproach. Much may be done, in every case, by a regular, systematic course of training, persisted in, if necessary, for several years. In most of my own cases, the improvement of speech was most marked before the end of the first six months; and the experience of other surgeons is equally decided upon this point.

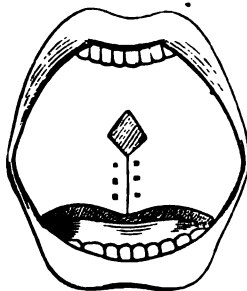
No statistics, on an extended scale, have been published of this operation. Sir William Fergusson had, up to 1865,

performed it in 134 cases, with only 5 failures. Dr. J. Mason Warren had 100 cases, in all of which, except half a dozen, he always got more or less union of the soft palate. Of this number, the gap in at least three-fourths involved, either partially or completely, the maxillary portion of the palatine vault. Nearly all my cases, upwards of twenty in number, have been successful. A few instances have been recorded in which the operation proved fatal.

Staphylorraphy was first successfully performed by Roux, of Paris, in 1825. It was first done by Lemonnier, upwards of a century ago, but had been neglected until it was revived by Graefe, in 1817. In this country, the names of the two Warrens, Stevens, Hosack, Smith, Mettauer, Gibson, Mütter, Pancoast, and others, are honorably associated with it, either on account of their successful exploits, or the invention and application of useful instruments.

Uranoplasty.—Fissures of the hard palate were formerly supposed to be irreme-

Fig. 410.

Unclosed Fissure in the Palate
after Staphylorraphy.

diable, and this idea, so long current, was not dispelled until 1843, when Dr. J. Mason Warren called attention to a peculiar operation, now very properly termed uranoplasty, for their relief, in the *New England Quarterly Journal of Medicine and Surgery*. Previously to this time, occasional attempts had been made to close openings in the hard palate, caused by wounds, caries, or necrosis, but they were so very different from those now practised for the cure of congenital clefts as hardly to deserve to be mentioned in the same category. The Boston surgeon is, therefore, exclusively entitled to the honor of being the first to perform uranoplasty upon correct, scientific principles.

The operation may, for the sake of simplicity, be considered as consisting of four stages: the paring of the edges of the fissure; a longitudinal, or slightly curvilinear, incision, carried along the alveolar border of the jaw, close to the teeth; the elevation of the muco-periosteal tissue from the roof of the mouth; and the union of the two flaps along the middle line. For making the lateral incisions along the alveolar border of the bone, a strong, spear-shaped, angular knife, fig. 411, or the instrument represented in fig. 412, is necessary; while, for elevating the mucous membrane and the periosteum, a steel instrument, resembling an oyster-knife, curved on the flat and blunt at the edges, does away with the risk of cutting the flaps, experience having shown that it is much safer to scrape the tissues from the bone than to dissect them up. Professor Langenbeck asserts, on the testimony of numerous trials upon the human subject, that the transplanted periosteum soon begins to pour out osseous matter, which eventually assumes all the firmness and density of veritable bone. Other operators, however, have not been so fortunate, and it is really, practically speaking, of no consequence whether the closure be effected by osseous or fibro-mucous tissue.

It is of very great importance, in raising the flaps, not to interfere with the incisive and posterior palatine foramina, as they give passage to the nutrient vessels, the division of which might not only cause embarrassing hemorrhage, but seriously compromise the success of the operation.

The flaps are stitched together precisely in the same manner as in staphylorrhaphy. Four sutures will generally suffice to effect thorough apposition, and they should be made of wire, instead of silk, as they will be less likely to cause irritation. They should be retained at least from eight to ten days. The patient should be well fed during the after-treatment, cough allayed with anodynes, and mucus cleared away with the sponge mop. If the fissure do not unite in its entire extent, another operation may be required soon after the effects of the first have been recovered from. Failures of this kind are, indeed, quite common, especially in the more complicated

Fig. 411.



Fig. 412.



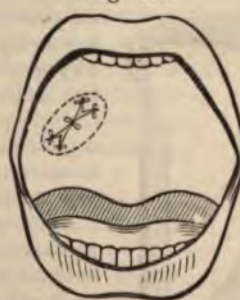
Knives for Uranoplasty.

Fig. 413.



Fissure of the Hard Palate.

Fig. 414.



Fissure of the Hard Palate, closed by Suture.

cases. The anterior extremity of the fissure especially is liable to gape; and, when this is the case, it is a question whether closure by an obturator would not be preferable to further interference with the knife.

Staphylorrhaphy and uranoplasty may often advantageously be performed at one sitting. If the case, however, be an unusually complicated one, it will be more prudent to do the work at separate periods, allowing a sufficient interval to elapse to enable the parts to recover from the effects of the operation.

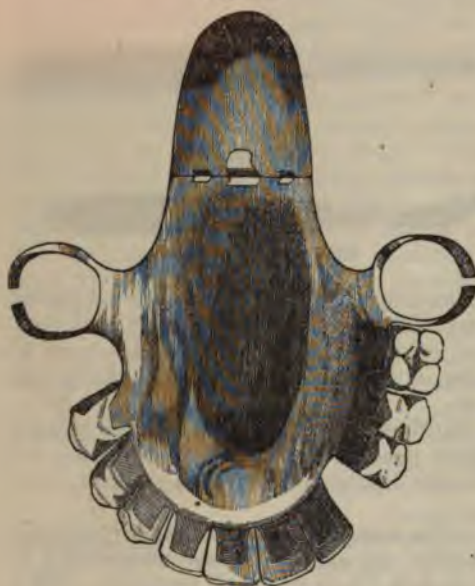
An operation similar to uranoplasty may be necessary when the roof of the mouth has been perforated by disease or accident. Upwards of thirty years ago I performed an operation of this kind upon a young gentleman, since deceased, with the most satisfactory results. The opening was fully half an inch in diameter, and the union was perfect in less than a week. Dr. J. M. Warren, to whom the credit of devising the operation is usually ascribed, has also performed it successfully. The nature of the procedure will readily be understood by a reference to figs. 413 and 414.

When uranoplasty fails, or when the case is unsuitable for operative interference, an obturator, made of gold, silver, or India-rubber, accurately fitted to the roof of the mouth, and secured to some of the teeth, may be worn, the individual being

thus enabled to masticate, swallow, and talk with rare facility. Such a contrivance, of which fig. 415 affords an excellent illustration, may readily be supplied, with or without teeth, by any ingenious dentist. Its great requisites are lightness and accurate adaptation.

The best obturator with which I am acquainted is the one devised by Dr. Kingsley, of New York, and improved by Dr. McQuillen, of this city. It is composed of elastic, vulcanized rubber, and is moulded with great accuracy to the size and shape of the fissure. It is extremely light, is easily retained in position, and readily contracts and expands under the action of the muscles of the palate; so that, with proper training, the individual soon learns to speak with a degree of facility and distinctness altogether surprising.

Fig. 415.



Obturator for the Palate.

SECT. VI.—AFFECTIONS OF THE TONSILS.

The diseases of the tonsils are few and simple, consisting mainly of inflammation and hypertrophy. Scirrhus and encephaloid have been noticed in them, but seldom, if ever, as independent affections. In nearly all the recorded cases of which I have any knowledge, they were associated with similar formations in other parts of the body.

Fig. 416.



Tongue Depressor.

To obtain a good view of these bodies, the patient is seated in a strong light, the mouth being opened as widely as possible, and the tongue depressed with a paper-folder, a wooden spatula, the handle of a spoon, or, what I generally prefer, a common grooved director. In chronic disease, the latter instrument may be advantageously used for uncovering the affected parts, by lifting off the anterior arch of the palate, and also for ascertaining the degree of their consistence. Holding the tongue perfectly quiet, while the patient is taking a long inspiration, will bring the tonsils fully into view, and at the same time prevent the unpleasant retching so liable to follow the contact of a foreign substance. When the tongue is unusually unmanageable, as it often is in children, and even in adults, the best depressor is the one represented in fig. 416. The instrument depicted in fig. 283, p. 379, and invented by Dr. Church, of New York, will be found to be of great assistance in tedious operations about the mouth, or when it is necessary to make

unusually careful examinations of the throat, depressing not only the tongue, but also separating the jaws.

In acute as well as in chronic affections it is often necessary to bring the remedies in immediate contact with the tonsils, gargling, as it is called, being in most cases either ineffectual, or wholly inadmissible. The articles most commonly employed are tincture of iodine and nitrate of silver, either in substance or solution. Lotions, of whatever description, should be applied by means of a large camel-hair brush, with a long handle, or a mop, consisting of a piece of soft sponge, about four lines in diameter, and secured to the end of a thin cylinder of wood, eight inches long. The sponge, being thoroughly wet, but not distended, with the fluid, and the tongue depressed in the manner above directed, is passed down into the throat, and pressed gently, but effectually, against every portion of the suffering surface, not only of the tonsils, but of the uvula and the arches of the palate, which generally participate in the disease. Solid substances, as sulphate of copper and nitrate of silver, are best applied in a long quill, or special carrier, the end being previously rounded off with a wet cloth.

Medicines may occasionally be advantageously employed, in the form of dry powder, directly to the mucous surface, by *insufflation*. Excellent effects may be obtained by this process, even when the substance cannot be brought in immediate contact with the affected part, as in the case of the larynx and trachea, the morbid action being apparently relieved by the sympathetic impression produced by depositing the remedy in the vicinity of the disease. The best means of applying dry powder is an insufflation-tube, slightly curved at the distal extremity, which should be perforated with numerous little apertures. A small gum-elastic bag, with a long, narrow nozzle, also answers well. The most desirable articles are alum, borax, tannic acid, nitrate of silver, and hydrochlorate of ammonia, either alone, or, what is generally better, mixed with pulverized sugar. The operation must not be too frequently repeated.

Atomized medicated liquids are now very fashionable in the treatment of diseases of the throat and fauces, and there is no doubt that they are among the most efficient agents that can be employed for the purpose. The articles usually selected are iron, in the form of subsulphate and the tincture of the chloride, alum, tannic acid, laudanum, and sulphate of quinine, well diluted with water, and introduced by an appropriate apparatus, such as that sketched in fig. 417. The application, which should not, at first, be very strong, may be repeated three, four, or even five times in the twenty-four hours, according to the exigencies of the case.

The *inhalation* of the vapor of hot water, either simple or medicated, may often be used with very marked benefit in affections of the tonsils, palate, fauces, larynx, and Eustachian tubes, and may readily be accomplished with a very cheap and simple apparatus, as that, for example, represented in fig. 418. The materials of which it consists are, a large glass bottle, with a wide mouth, a soft, closely fitting cork, and two glass tubes, the one straight, to convey the external air below the surface of the liquid, the other curved, to serve as a mouth-piece, or as an inhaler, properly so called. The articles commonly used for medicating the water are laudanum, spirit of camphor, creasote, guaiacum, and iodine, the latter two in the form of tincture.

Scarification of the tonsils is occasionally performed for the relief of inflammatory engorgement. The operation is effected by drawing a sharp bistoury, guarded to within a line of its point, rapidly across the mucous membrane in half a dozen different directions. Discharge is encouraged by gargling freely with warm water. If clots form in the incisions, they are removed with the mop, finger, or director. Scarification of the tonsils and palate, although a favorite practice with some, has usually disappointed my expectations, and I, therefore, seldom

Fig. 417.



Handball Spray-producer.

Fig. 418.



Inhaler.

employ it, except when there is inordinate œdema of the submucous cellular tissue. Even in such cases, however, more prompt relief will generally follow the application of the dilute tincture of iodine, or a strong solution of nitrate of silver. When the swelling is great and urgent, a few tolerably deep incisions will be advantageous.

1. *Acute Tonsillitis*.—Acute inflammation of the tonsils is exceedingly common, especially in young persons of a delicate, strumous constitution, and is often induced by the most trivial causes, of which the most frequent is exposure to cold. It occurs at all periods of life, in both sexes, and at all seasons of the year, being most common, however, in winter and spring. The attack is generally rather sudden, and is apt, if unchecked, to proceed with considerable rapidity. To a sense of soreness and stiffness in the throat, with a disagreeable, but indescribable, feeling, which marks the stage of invasion, are soon superadded great difficulty of swallowing, severe pain, and a constant desire to clear the fauces of mucus, which is always very ropy, adhesive, and abundant, and the effort to detach which constitutes a source of real suffering. The pain soon extends to the face, ears, and neck, and, the mechanical obstruction increasing, the breathing becomes much embarrassed, sometimes, indeed, almost to the extent of suffocation. If the patient attempts to drink, the fluid regurgitates by the nose, and often nearly strangles him; his head is thrown backwards, in order that the mouth and larynx may be brought more into a straight line; and, during sleep, he snores with a loud noise. The lymphatic glands, at the base of the jaw, are frequently swollen and tender; and there are few cases of any severity in which there is not high fever. On inspecting the mouth, which is often done with great difficulty, the tonsils are found to be very much enlarged, and of a deep, almost fiery, red color, with here and there a speck, patch, or streak of firmly adherent lymph. From its peculiar color and shape, this substance frequently imparts to the glands an ulcerated appearance; but a careful examination soon serves to dispel the illusion. The arches of the palate, uvula, fauces, and root of the tongue, always participate in the morbid action, being red, tumid, and painful. Generally both tonsils are involved, although seldom in an equal degree.

The treatment of acute tonsillitis is by antiphlogistics, early and vigorously employed, and persisted in until there is decided abatement of the morbid action. If plethora exist, blood is taken by a large orifice from the arm, and by leeches from the neck, directly opposite the inflamed organs; the bowels are thoroughly evacuated; and, if there is much mechanical obstruction, a brisk emetic is administered. When the disease is very mild, or in its incipency, prompt relief generally follows the prolonged use of the foot-bath, a full dose of Dover's powder, and the wet towel around the neck. In violent cases, besides the means already mentioned, scarification, and even incision, may be required, to remove tension and vascular engorgement. As to gargles, little reliance is to be placed upon any of them in any form of the disease, or in any of its stages, owing to the difficulty of bringing them in contact with the inflamed surfaces. When such remedies are indicated, it will always be better to mop the parts well with dilute tincture of iodine, or to touch them very gently with the solid nitrate of silver. The former application is particularly beneficial in the œdematous variety of tonsillitis, in which it often acts like a charm in relieving the mechanical obstruction caused by the effused fluids. The proper proportions, except in young children and very delicate persons, are equal parts of the tincture and of alcohol, applied, if need be, at intervals of ten to twelve hours. When the inflammation is diffuse and urgent, the neck should be buried in a thick, warm cataplasm.

When the tumefaction is very great, the tonsils may nearly fill up the fauces, and encroach so much upon the epiglottis as to interfere materially with respiration. In such an emergency, prompt relief must be afforded, or the patient may perish from suffocation. The plan to be pursued is to excise a portion of the affected glands at the middle line; or, this failing, to open the larynx. To let a man die from such a cause would hardly be less criminal than to kill him. If the operation be delayed too long, death may occur from the shock sustained by the system, in consequence of the struggles to maintain the respiratory functions.

2. *Gangrene*.—Gangrene of the tonsils is most frequently met with in connection with scarlatina, smallpox, and syphilis; as an event of ordinary inflammation, it is extremely rare. A fetid state of the breath, a foul, livid appearance of the affected glands, and a dark, sanious discharge from the throat, with difficulty of deglutition, severe pain, and high fever, are the characteristic symptoms. The surrounding

structures, as the uvula and arches of the palate, usually participate in the mischief, exhibiting similar appearances, and augmenting the suffering. The treatment, as a general rule, is by stimulants; by brandy and quinine internally, and by the acid nitrate of mercury, carbolic acid, nitrate of silver, or sulphate of copper locally. If the gangrene has been induced by syphilis, for which a course of mercury has been employed, the remedy is at once suspended, lest the destructive process be fostered instead of being diminished.

3. *Ulceration*.—Ulcers, both common and specific, are liable to occur in the tonsils, or in these organs, the palate, and the fauces. The former are rare, and are usually produced by derangement of the digestive apparatus; they are small, irregular, superficial, and associated with a reddish, flabby condition of the throat, with a tendency to the formation of aphthæ or plastic deposits. Removal of the exciting cause, with purgatives and alterants, is generally sufficient for their cure; aided, if necessary, by light applications of nitrate of silver. Of the venereal ulcer of the tonsils there are several varieties, as the excavated, the diphtheritic, and phagedenic; but, as these are described in the first volume, no particular account of them is required here.

4. *Abscess*.—Acute tonsillitis now and then terminates in abscess; the matter is seldom abundant, but often very offensive, and the symptoms are usually very urgent, from the mechanical obstruction caused by the inflamed and tumefied organs. The formation of pus is generally ushered in by an aggravation of the local and constitutional distress, as throbbing pain, livid discoloration of the mucous membrane, and rapid increase of swelling, together with rigors and high fever. On looking into the mouth, the tonsils, especially if both suffer in an equal degree, are found to touch each other at the middle line, leaving, perhaps, merely a small interval at their upper extremity, which is itself often nearly entirely closed by the enlarged and pendulous uvula. The patient breathes with immense difficulty, and appears as if he were in imminent danger of suffocation. The matter generally forms within the first five days after the commencement of the attack, and, in rare cases, even considerably earlier. It may appear simultaneously in both glands, or be limited to one.

The treatment is rigorously antiphlogistic; and spontaneous evacuation, which might permit the matter to fall into the larynx, and so cause suffocation, is anticipated by early and free incision. A long, straight, sharp-pointed bistoury, wrapped to within the third of an inch of its extremity, is passed into the mouth, with the back towards the tongue, until it reaches the swelling, into the centre of which it is thrust with the requisite degree of force, the opening being afterwards enlarged to the desired extent by inclining the instrument over towards the middle line. The head of the patient is held firmly by an assistant, lest he should push it forwards or to either side, and so endanger the internal carotid artery. For the same reason, the knife is kept away from the angle of the jaw. In the natural state, the tonsil is at least five or six lines from this vessel; but, when the gland is much tumefied, the distance between them is sensibly diminished. Smart bleeding, from the division of the tonsillary artery, occasionally follows the operation, and is generally decidedly advantageous in allaying inflammation; it commonly ceases in a few minutes, and is always, if necessary, easily arrested by astringent gargles.

5. *Hypertrophy*.—Hypertrophy or chronic enlargement of the tonsils, represented in fig. 419, is exceedingly common, and is met with almost exclusively in young, strumous subjects. I have seen it repeatedly in children under eighteen months of age, and in several instances that have fallen under my observation, there was every reason to believe that it was congenital, the affection having been noticed within a few days after birth. It rarely makes its appearance after the thirtieth year, unless it has existed earlier in life, and been only partially relieved. Old persons are entirely exempt from it. From its history and progress, it is obvious that it is always of a scrofulous nature. It occurs with equal frequency, or nearly so, in both sexes.

The disease usually takes place slowly; and, although both glands are commonly involved, they seldom suffer in an equal degree. Generally speaking, they enlarge in every direction, and thus

Fig. 419.



Enlarged Tonsils.

encroach more or less upon the surrounding parts, as the base of the tongue, palate, larynx, and Eustachian tubes. Not unfrequently they touch each other at the middle line, leaving, perhaps, merely a small chink above and below for the passage of the air. Their color and consistence are liable to considerable diversity. In young subjects they are usually quite red, and so soft as to give way under the slightest pressure and traction. At this age, I have occasionally met with a peculiar foliaceous arrangement of the gland, its substance being spread out in distinct strata, of a red color, very vascular, and remarkably friable. In cases of long standing, and, indeed, as a general rule, the organs are of a bluish, pink complexion, and of a tough, firm consistence. At other times, again, although rarely, they are almost of scirrhus hardness. Their follicles, ordinarily much enlarged, often contain plugs of lymph, inspissated mucus, caseous matter, or calcareous concretions. When very patulous, they impart to the surface of the hypertrophied tonsil an appearance similar to that of the lid of a pepper-box, as in fig. 420, from a clinical case. The shape of the gland is generally irregularly elongated, but now and then almost globular. The uvula, the arches of the palate, and the mucous membrane of the fauces, almost invariably participate in the diseased action.

Fig. 420.



Hypertrophy of the Tonsil.

It is questionable whether the tonsils would ever suffer from chronic enlargement, or, at any rate, remain long in this condition, if there were not always a constitutional predisposition to its occurrence. The affection, as already remarked, is mostly of a strumous character. Hence, the most trivial circumstance, as exposure to cold, suppression of the cutaneous perspiration, or derangement of the digestive apparatus, is generally sufficient to provoke it. The frequent recurrence of the act maintains and reëxcites the inflammation and the hyperplasia of the lymphadenoid tissue, which are the immediate causes of the enlargement and induration from which the affection derives its distinctive features. Whether there is often a deposit of tubercular matter in the hypertrophied organs has not been demonstrated; but that the enlarged follicles occasionally contain a substance of this description, or of one very closely resembling it, the results of my examinations abundantly attest.

Enlargement of the tonsils, unless considerable, is not necessarily attended with any unpleasant symptoms; the only inconvenience experienced being, perhaps, a sense of fullness and occasional soreness of the throat. These effects are invariably aggravated when the patient takes cold, or labors under derangement of the general health. In the more confirmed forms of hypertrophy, however, the local suffering is always proportionately great, from the mechanical obstruction from the enlarged glands. The voice is husky, nasal, and disagreeable; the respiration is impeded; and there is an uneasy feeling in the throat, with a remarkable tendency to inflammation. When the tonsils are so large as to be almost in contact with each other, the distress is greatly augmented. During sleep a low moaning is usually present, accompanied with snoring and stertorous breathing, and the head is strongly retracted, so as to bring the mouth on a line with the windpipe, evidently for the purpose of facilitating the ingress of the air. In cases of very long standing, distortion of the features is apt to arise; the nostrils are habitually dilated; the mouth is half open; and the whole countenance has a dull, vague expression. Partial deafness, from obstruction of the Eustachian tube, occasionally exists; and the chest is liable to become arched behind, flattened in front, and contracted at the sides. This deformity is sometimes present in a surprising degree at an early period of life. I have seen a number of well-marked examples of it in children under six years of age.

A great variety of means have been tried for arresting the progress of this affection, and for promoting the absorption of the interstitial new formations, so as to restore the glands to their primitive condition. Very few of them, however, are found to have the desired effect, especially when the disease is fully established. The remedies most worthy of reliance are iodine and kindred articles, administered internally, and applied to the affected parts. The tincture of iodine, diluted with three or four parts of alcohol, and a weak solution of the iodide of iron, applied once every other day by means of a soft mop, are both valuable sorbefacients, and may occasionally be used with advantage. Nitrate of silver is also beneficial, especially in its fluid

form. The proper strength, in children, is from fifteen to twenty grains of the salt to the ounce of water; in adults, it should be at least double. Numerous and repeated punctures with the point of a delicate bistoury have sometimes been attended with good results in my hands; they serve to disgorge the capillary vessels, and to pro-

Fig. 421.

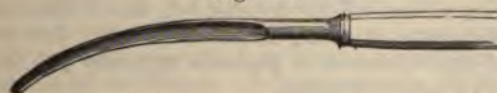


Voisella.

mote the absorption of the hypertrophied tissues; two most important indications in the treatment. Frequent compression of the enlarged gland with the finger has been suggested; but the trials that I have made with it have disappointed my expectations. With these means may be conjoined, sometimes with advantage, the application of leeches, embrocations, and stimulating unguents to the neck. In all cases, due attention is paid to the state of the general system; the diet is carefully regulated; the bowels are maintained in a soluble condition; and, when there is any evidence of debility, tonics, especially iron and quinine, are freely exhibited.

The above treatment failing, as, unfortunately, it is too apt to do, the only thing

Fig. 422.



Probe-pointed Bistoury.

to be done is to excise a portion of the enlarged bodies, so as to enable the air to enter the lungs with its accustomed freedom. The operation performed with this view consists in seizing each gland with a double hook, fig. 421, and cutting off all that part of it which lies exterior to the arches of the palate with a curved, probe-pointed bistoury, seen in fig. 422. The instrument is carried from below upwards, with the back towards the tongue, excision being effected almost in an instant, with hardly any pain or hemorrhage. The hook and knife, with which it is my custom to perform the operation, and which are here represented, are altogether superior to the tonsillotomes of Physick, Gibson, Fahnestock, and other surgeons. They are each about eight inches in length. The great objection to tonsillotomes is that the ring, at the distal extremity, is rarely sufficiently large to receive the hypertrophied gland in its embrace, so as to allow us to cut off as much as is necessary. In children I have occasionally used such an instrument with excellent effect. The neatest tonsillotome is that of Fahnestock, represented in fig. 423. When both tonsils require removal, and the surgeon is not ambidextrous, the operation may be performed very easily with the right hand.

In operating with the knife the tonsil, if only partially cut, may fall backwards upon the mouth of the larynx, and cause symptoms of suffocation. Wiseman and Moscati refer to cases where death was thus produced. To guard against such an occurrence the surgeon should never relax his hold upon the gland.

Excision of the tonsils is simple enough in the adult, but in the child it is often attended with immense difficulty, on account of his cries and struggles. Indeed, there are few operations which, under such circumstances, are more annoying and perplexing than this. To overcome this difficulty the best plan is to wrap up the child firmly in an apron and to have him well supported by assistants; or, what I prefer, to administer a small quantity of chloroform, just enough to produce partial insensibility. In this

Fig. 423.



Fahnestock's Tonsillotome.

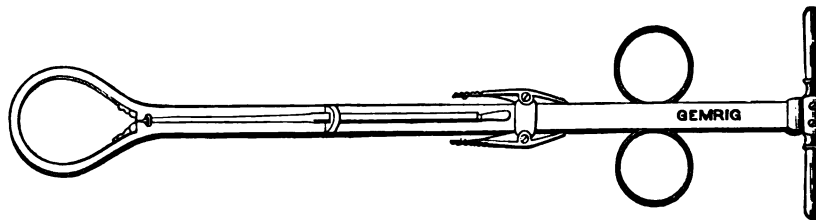
manner one tonsil being removed, the little patient is allowed time to clear his throat, when, the agent being again inhaled, the operation is completed by excising the other. The best depressor of the tongue is the surgeon's index finger. The interposition of a piece of cork between the teeth is usually an awkward and unnecessary proceeding.

I have twice removed the tonsils at the same sitting for children under twelve months of age without any ill effects. When the enlargement, however, is very great, or the little patient unusually delicate, the best plan is to excise only one gland at a time, clipping off the other at the end of a fortnight.

The operation above described, although generally free from hemorrhage, is not so always. In 1849 I performed it upon a lad eleven years of age, in whom the bleeding was not only copious, but absolutely alarming. Both tonsils were much enlarged, and were accordingly excised; the right bled hardly any, but from the left the blood issued at numerous points, and was spat up every few seconds in large mouthfuls. Much also was swallowed, and afterwards ejected by vomiting. The entire quantity amounted to nearly twenty ounces. The boy, although for a short time very pale, feeble, and nauseated, soon recovered from the effects of the operation. The remedies used for arresting the hemorrhage were, first, sulphate of copper, and afterwards powdered alum, applied freely by means of a sponge mop, ice to the neck, and a full dose of laudanum, with thorough elevation of the head, and exposure of the mouth and body to a current of cold air. The lad slept well the following night, without any recurrence of the bleeding. There was no evidence of a hemorrhagic diathesis. An equally remarkable case of bleeding in a youth of fourteen, from excision of one of the tonsils, fell, many years ago, under the observation of a former colleague of mine, Professor Cobb. The portion of gland removed did not exceed the volume of a pigeon's egg, and yet the flow of blood was so copious as almost to induce syncope.

I have lately met with four other cases of severe bleeding after this operation; one in a youth of eighteen, one in a man of thirty, one in a lady of twenty, and one in a man of twenty-seven. Neither of the first two presented any apparent peculiarity prior to the excision. The hemorrhage in both was copious, but finally yielded to the application of the tincture of the chloride of iron, along with a full anodyne. The man lost upwards of a quart of blood. In the third and fourth cases, however, ordinary measures were powerless, and the bleeding was only restrained by firmly compressing the gland with a stout pair of deeply serrated forceps. In the case of the young lady the hemorrhage recurred on several occasions. Both of these patients were pale and anemic. In such subjects, as a matter of precaution, it would be better to remove the gland with the tonsil écraseur, recently devised by Dr. S. W. Gross, and delineated in fig. 424. Guersant is said to have operated upon more than one thousand children, with only three cases of troublesome bleeding.

Fig. 424.



Tonsil Ecraseur.

When the hemorrhage proceeds from the division of the tonsillary artery, it may be necessary, in the event of the failure of styptics, such as sulphate of iron, alum, creasote, or sulphate of copper, to seize and compress the bleeding orifice with a light pair of forceps, retained temporarily in the mouth. Erichsen refers to a case in which the hemorrhage was effectually arrested, after the failure of all other means, by a gargle of spirits of turpentine suspended in mucilage. The mouth should always be kept widely open, to admit the air freely, and ice should be applied to the angle of the jaw and nape of the neck. In a case lately reported by Mr. W. P. Hood,

of London, the bleeding was arrested by spontaneous vomiting, and in another by the effects of an emetic. Subsulphate of iron should be used with great caution in such a condition, otherwise some of the clotted blood might fall into the larynx, and thus cause fatal asphyxia.

After removal of the tonsils, the patient should be confined for several days to a moderately warm apartment, and take, if necessary on account of the severity of the resulting inflammation, an active cathartic. I have heard of several cases in which death was caused by premature exposure.

6. *Calculus Concretions*.—Calculus concretions, varying in size from a mustard seed to a small cherry, and of a rounded, oval, or pyriform shape, are sometimes seen in the tonsils, chiefly in strumous subjects, in connection with chronic inflammation, which they are instrumental in aggravating and keeping up. They are of a dirty olive color, granulated on the surface, opaque, cretaceous in their consistence, and composed principally of carbonate and phosphate of lime, in union with animal matter. Their presence is generally detected accidentally. If allowed to remain, they are liable to provoke suppuration of the tonsils, attended with great local and constitutional suffering. A slight incision is usually sufficient to effect their liberation. When they protrude at the orifice of a mucous crypt, they may easily be extracted with the polyp-forceps.

A calculus of the tonsil is sometimes a cause of abscess, the matter of which may ultimately find an outlet in the neck, near the angle of the jaw, and keep up a great deal of irritation and suffering.

7. *Serous Cysts*.—The tonsil is occasionally, although very rarely, the seat of a serous cyst, filled with a thin, watery fluid, or a thick, ropy substance, resembling the white of an egg. The tumor is usually small, and may be suspected to exist when the gland has a whitish, translucent appearance, with a sense of fluctuation on the application of the finger. No pain attends its formation, and the only inconvenience which it produces arises from its mechanical obstruction. The treatment is by incision, followed by the application of nitrate of silver, tincture of iodine, or chromic acid, to excite obliterative inflammation.

8. *Polypoid Fibroma*.—These organs are now and then the seat of a fibrous polyp, as in a case under my observation, not long ago, in a man, thirty-five years old, affected with chronic asthma. The tumor, which was of a whitish aspect, and of the shape of the kidney, was very firm and dense, of a fibrous structure, three lines in length, and attached, by a narrow pedicle, about the twelfth of an inch long, to the centre of the right tonsil, which was otherwise apparently quite sound. The man had not been aware of the presence of the tumor until its removal, which was readily effected with the volsella and scissors.

9. *Chronic Abscess*.—A chronic abscess sometimes forms in the tonsils, evidently as a result of the strumous diathesis. It generally occurs in young persons, in association with tuberculosis of the lungs. The abscess, which is always very tardy in its progress, and free from pain, seldom exceeds the volume of a pigeon's egg, and may generally be easily recognized by the whitish, grayish, or drab-colored aspect which it imparts to the surface of the gland. Its contents are characteristic. The proper remedy is free incision. Should the cavity of the abscess be slow in healing, it should occasionally be gently cauterized with nitrate of silver.

10. *Carcinoma*.—Carcinoma of these organs is extremely rare, especially as an independent affection. Most generally it is of secondary origin, or coexists with similar disease in other structures, more particularly the lymphatic glands of the neck. The most common form is the soft, medullary epithelioma, of which I have seen two well-marked examples, one in a female upwards of forty years of age, and the other in a young man of twenty-three. Both proved fatal, without any attempt at removal; one from suffocation, and the other from gradual exhaustion brought on by repeated hemorrhages and hectic irritation.

Medullary carcinoma, originally limited to one tonsil, may eventually involve the other, as well as the soft palate, and the lymphatic glands at the angle and base of the jaw. It usually progresses rapidly and may in time acquire such a bulk as almost to close the fauces, thus causing great embarrassment in articulation, respiration, and deglutition. The tumor is of a red purplish color, dense in consistence, and more or less irregular upon the surface; features which, added to the rapidity of its development and its great size, readily distinguish it from ordinary hypertrophy of these bodies and the effects of syphilitic disease. When the affection has

attained the ulcerative stage, and is attended with sanious, offensive discharge, and signs of the carcinomatous cachexia, the diagnosis cannot be mistaken.

Scirrhus of the tonsils is still more rare than epithelioma; and I am not aware that melanosis and colloid have ever been observed in these organs; certainly not as independent affections.

The only resource in carcinoma of the tonsil is excision, practised either through the mouth, or neck, as in a case lately under the charge of Dr. Cheever, of Boston. In either event, there will be likely to be copious hemorrhage. When the operation is performed through the mouth, the affected organ should be seized with a stout volsella, and rapidly removed with the bistoury, the patient's head being held firmly by an assistant, the mouth opened by a speculum, and the bleeding arrested by Monsel's salt and the heated iron. In a case of amygdalotomy practised by Velpeau on account of carcinoma of the tonsil, a temporary ligature was placed around the carotid artery, to be tightened in the event of copious hemorrhage during the excision; but the result showed that this precaution was unnecessary. In the case of Dr. Cheever, two incisions were made, a short one along the lower border of the jaw, and the other, three inches and a half in length, extending from just within the angle of the jaw downwards on a line with the anterior margin of the sterno-mastoid muscle. After turning up the flaps, and enucleating a carcinomatous lymphatic gland, the dissection was continued until the tonsil was reached; a procedure which required the division of the stylo-hyoid and stylo-glossal muscles, and a separation of the fibres of the superior constrictor of the pharynx, the latter of which was then opened in the interval, and the diseased organ, a mass of encephaloid, the size of a pullet's egg, removed. No important nerves were cut. Twelve ligatures were applied. No untoward symptoms arose, and at the end of a month the large wound was completely closed. The operation, the first of its kind ever performed, reflects great credit upon Dr. Cheever's skill and judgment.

11. *Sarcoma*.—Sarcoma of the tonsil is still more uncommon than carcinoma. Billroth met with an instance of the affection in 1865, and a woman, forty-five years of age, was brought to my clinic, in 1871, on account of a medullary, round-celled sarcoma of the left gland, which was first noticed six months previously. The tumor, which was somewhat prominent in the neck, had displaced the soft palate and uvula forwards and to the right side, and was nearly in contact with the opposite gland, thereby seriously interfering with respiration, deglutition, and articulation. It was soft and elastic to the touch, its surface was smooth, there was no enlargement of the superficial veins, and the mucous membrane was unchanged. A lymphatic gland, of the volume of a bean, could be detected at the middle of the inner border of the sterno-mastoid muscle. Attempts to remove the mass with the *écraseur* were fruitless, on account of its great softness and friability; but I finally succeeded in digging it away piecemeal with the fingers and forceps. The hemorrhage was trivial, and the symptoms of obstruction were at once relieved. Two weeks subsequently, when I saw the patient for the last time, the parts were granulating nicely; but she died, as I learned afterwards, in less than a month from a recurrence of the disease. A small quantity of cloudy fluid could be scraped from the surface of the tumor, which was found by Dr. Bertolet to be composed entirely of small, friable, round cells, with very little protoplasm, so that the comparatively large nuclei with their shining nucleoli were free from the bodies of the cells. The intercellular substance, of a hyaline, almost formless appearance, was very sparsely developed.

SECT. VII.—AFFECTIONS OF THE UVULA.

The principal affections of this body are acute inflammation and chronic enlargement. In the former, which generally coexists with acute disease of the tonsils and palate, the organ is swollen, of a fiery red, or pale ash color, elongated, and cedematous. Its free extremity is sometimes expanded into a kind of watery bag, which, especially if there is at the same time great tumefaction of the tonsils, often alarmingly obstructs respiration, and necessitates the promptest interference. The treatment consists in touching the part effectually with the dilute tincture of iodine, nitrate of silver, or powdered alum and capsicum. When the enlargement is excessive, or decidedly cedematous, scarification may be required, or even excision of the free extremity of the organ.

The uvula, from debility, inflammation, and other causes, is liable to chronic en-

largement, especially to elongation. The elongation varies in extent from the slightest increase of the part to several times the normal length. An increase of length is usually associated with an increase of thickness, although not necessarily so, for an elongated uvula is occasionally remarkably narrow and tapering. Chronic enlargement of this organ may occur at any period of life, but is most common in young and middle-aged subjects, and is generally the result of repeated attacks of cold, operating upon a delicate and feeble constitution. It is usually conjoined with inflammation of the palate, tonsils, and fauces, derangement of the digestive apparatus, and a strumous diathesis.

Very disagreeable effects may be produced by an elongated uvula. Thus, the affected organ may project down into the rima of the glottis, occasioning aphonia, or a change in the tone and power of the voice, and a sense of strangulation. I recollect one case where the patient had repeated attacks of nightmare from this cause, which were promptly cured by the excision of a portion of this organ. The more common effects, however, are obstinate and protracted cough, with frequent desire to clear the throat, titillation of the fauces, dryness of the mucous membrane, and a feeling of constriction and frequent hawking. When the affection continues long, tubercles sometimes form in the lungs, and the patient ultimately dies under all the symptoms of confirmed phthisis.

The uvula is occasionally productive of disagreeable effects from mere relaxation of the soft palate, independently of any particular disease of its own substance. The palate, thus affected, hangs down into the fauces, and thereby permits the organ to infringe upon the larynx and root of the tongue in the same manner as in actual elongation. Such a condition is very common in dyspeptic and consumptive subjects, in whom it often constitutes a source of great annoyance.

The only reliable remedy for this affection is excision of the uvula. All astringent lotions, washes, gargles, and sprays are perfectly useless, and, therefore, no time should be wasted in their employment. The patient sitting upon a chair, opposite a good light, the surgeon depresses the tongue, and with a polyp-forceps seizes the apex of the uvula, which is then cut off with a pair of probe-pointed scissors, slightly curved upon the flat. An instrument, which combines both forceps and scissors, and which is delineated in fig. 425, will be found convenient in performing this little operation. Not more than about one third of an inch of the organ should be left, otherwise the elongation may ultimately be reinduced, and so demand another operation. In a few instances I have removed nearly the whole of this body, without, so far as could be discovered, any injurious effects. It has been asserted that, when the excision is performed near the base of the uvula, there will occasionally be a serious change in the voice, but of this I have never seen any examples. If I were obliged to operate upon a professed singer, I should certainly limit myself to the removal of a comparatively small portion of the elongated organ, lest unpleasant consequences of this nature might arise. The operation, as here advised, is so simple that any one may perform it. No hemorrhage need be looked for, nor is the excision attended with any pain. The diet for the first few days must be chiefly liquid.

Fig. 425.



Forceps-scissors.

SECT. VIII.—AFFECTIONS OF THE PHARYNX AND OESOPHAGUS.

The exquisite sensibility of the palate renders it often extremely difficult, if not impossible, to make a satisfactory examination of the throat, with a view to the detection and treatment of its diseases. The moment the parts are touched they contract spasmodically, and excite a tendency to vomiting, attended with such a degree of constriction as effectually to stop the proceeding. This sensibility, which is natural to all persons, is frequently greatly heightened by disease, and can, in general, be overcome only by a systematic course of training, or by the exhibition of an anæsthetic. Commonly, a sufficiently good view may be obtained by requesting the patient to take a long inspiration; but even this cannot always be done by a

nervous individual, and the surgeon is then obliged to depress the tongue, and explore the parts as best he may. When more than ordinary care is required, the *pharyngoscope* must be employed. A very excellent instrument of this kind, invented by Dr. Duplay, is delineated at p. 364. It is simply a modification of that of Simrock, and answers the double purpose of a rhinoscope and pharyngoscope. In cloudy weather, the parts may be illuminated with an Argand lamp, or a Lewin's lantern, by means of which the light may be concentrated, and transmitted through a strong convex lens. The uvula, palate, and tonsils may be held out of the way during the inspection with a hook, spatula, or large probe. The œsophagus may be explored in a similar manner. With proper patience, and with the aid of a simple dilating instrument, a good view of the tube may readily be obtained as far down as the level of the cricoid cartilage.

The affections of these two tubes, which, in structure and function, are intimately associated, may conveniently be considered together. The most common and important are, inflammation, abscesses, wounds, strictures, malignant growths, and foreign bodies.

1. *Congenital Malformations.*—The pharynx and œsophagus are subject to various malformations, some, if not most, of which are inconsistent with the continuance of life. The pharynx occasionally ends in a cul-de-sac; and, in acephalous monsters, a total deficiency of the tube has been observed. Sir Astley Cooper met with an instance in which a blind pouch of the pharynx coexisted with absence of the œsophagus; and cases have been seen in which the tube, instead of terminating in a cul-de-sac, opened by a small orifice at the side of the neck.

The most common malformation of the œsophagus is that in which the superior portion of the tube presents itself as a cul-de-sac, from an inch to an inch and a half in length, terminating either in a narrow, constricted canal, or in an impervious, fibro-cellular cord. Sometimes there are two separate pouches, one above the other, with an intermediate solid substance. Occasionally, again, there is a division of a portion of the œsophagus into two canals, placed side by side. In rare instances, as in those recorded by Vrolik, Martin, and Levy, the œsophagus communicates with the trachea a short distance above its bifurcation. In a case observed by Mr. Annandale, of Edinburgh, the tube was dilated into a blind sac, of a rounded shape, which opened by a hole, the size of a crow-quill, into the posterior surface of the trachea. Immediately below this the continuity of the tube was almost lost, when it became again pervious, and so continued until it reached the stomach.

Many of these congenital malformations are associated with defects of the palate, jaws, and mouth, and their existence during life can only be determined by the use of the bougie. For their relief, gastrostomy has been proposed, but never, so far as I know, performed.

2. *Hyperæsthesia.*—The mucous lining of the pharynx and œsophagus, especially of the former, is often the seat of excessive morbid sensibility, generally the result of repeated attacks of cold, leaving the parts in a weakened and irritable condition. It is most common in females, of a nervous, hysterical temperament, and is liable to occur at all periods of life, but is most frequent in children and young adults. Cough, of a hacking and annoying character, with a frequent desire to clear the throat, is one of the most constant and unfailing symptoms. A good deal of thick, tough, inspissated mucus, more or less firmly adherent, is generally present, and adds not a little to the patient's distress. A sense of titillation is usually experienced in the parts, and is one of the principal causes of the accompanying cough. The morbid sensibility, in time, commonly extends to the surrounding structures, as the larynx, the root of the tongue, and the posterior nares; and the lining membrane at the seat of the disease not unfrequently exhibits evidences of chronic disease, as inflammation, hypertrophy of the muciparous glands, and the existence of granulations. The general health rarely suffers; sometimes, however, there is marked dyspepsia, and even a disposition to pulmonary phthisis, increased by the constant efforts at coughing and clearing the throat.

The most effectual remedy is a solution of nitrate of silver, applied once every fourth or fifth day, with a large camel-hair pencil. The strength of the solution should vary from twenty to thirty grains. Constitutional means must not be neglected. The secretions must be attended to, and tonics must be employed if the patient is feeble or anemic. A permanent cure can seldom be effected without long-continued efforts in the treatment.

3. *Neuralgia*.—Neuralgia of these tubes is generally associated with neuralgia in other parts of the body, especially of the head, face, and chest; but it also occurs as an independent affection. It is most common in the pharynx, or pharynx and superior portion of the œsophagus, in women of a nervous temperament, the subjects of dyspepsia and disordered uterine function. The disease is characterized by dull, aching pains, more or less steady, seldom distinctly paroxysmal, and generally attended with a sense of fatigue and fullness in the throat, an inordinate secretion of mucus, and a frequent desire to hawk and spit. Not unfrequently there is a feeling of spasm, or even of slight suffocation; and cases occur in which dysphagia is a marked symptom throughout. The general health, at first unimpaired, eventually suffers; the countenance becomes wan and sallow, the appetite is deranged, the bowels are constipated, and the strength is much reduced. The disease is sometimes of malarial origin.

The diagnosis is founded on the history of the case, the peculiar character of the pain, and the absence of organic disease. The bougie must be used when obstruction exists.

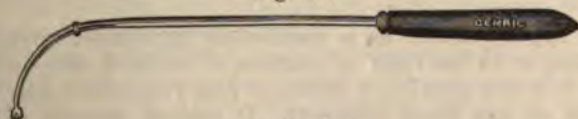
The treatment resolves itself into the correction of the secretions, a proper regulation of the diet, and the use of antineuralgic remedies, especially quinine and arsenic, combined, in obstinate cases, with change of air and scene. Chloral, bromide of ammonium, and iron will be serviceable when the patient is very nervous and anemic. Spasm is generally promptly relieved by the bougie.

4. *Pharyngitis*.—Although inflammation of the pharynx occasionally exists as an independent affection, it is generally associated with, or a consequence of, disease of the palate and tonsils. Ordinary causes, as suppression of the cutaneous perspiration, or the lodgment of a foreign body, may produce it; or it may be induced by the syphilitic poison, by a strumous taint of the system, or by the contact of a corrosive substance, as nitric, sulphuric, or hydrochloric acid. The inhalation of steam and the swallowing of hot water are often followed by intense inflammation, both of the pharynx and œsophagus.

The symptoms will be more or less urgent, according to the violence and duration of the morbid action. Impediment in deglutition, a frequent desire to clear the throat, and a copious secretion of thick, ropy mucus are generally the most conspicuous phenomena. In the more violent forms of the disease, the patient often experiences severe pain and spasm, especially in the attempt to swallow liquids, which frequently regurgitate by the mouth and nose; the voice is hoarse and croaking; and there is occasionally not a little embarrassment in breathing, from an extension, apparently, of the inflammation to the windpipe. Considerable swelling, chiefly of a glandular nature, sometimes exists in the neck, along the base of the jaw, and in the gutter below the ears. The lining membrane of the pharynx is of a deep red color, its follicles are much enlarged, and its surface is covered with thick, ropy mucus, and, here and there, even with plastic matter. In severe cases, the inflammation extends up into the nose, forwards over the palate, and down into the larynx. The constitutional symptoms vary with the intensity of the local action, and need not, as they exhibit no peculiarities, be described.

The treatment is antiphlogistic; by the lancet and antimonials, if there be much local and constitutional excitement, along with purgatives, diaphoretics, and anodynes, and by leeches to the neck, with tepid, acidulated gargles, scarification, especially if the inflamed surface is within reach, and the application of nitrate of silver,

Fig. 426.



Sponge-holder.

either in substance or in strong solution. When the tube is loaded with ropy mucus, attended with a frequent desire to clear the throat, great relief will follow an emetic. Warm applications to the neck, in the form of poultice or fomentation, and the inhalation of the steam of warm water, are occasionally beneficial. If gangrene is threatened, the parts are promptly and efficiently touched with nitrate of silver, or, what

is preferable, a weak solution of acid nitrate of mercury. These agents may readily be applied to every portion of the pharynx by means of a piece of sponge secured in the blades of the instrument delineated in fig. 426.

5. *Abscess*.—An abscess, generally of a *strumous* nature, occasionally forms in the upper part of the pharynx, beneath the mucous membrane in front of the cervical vertebræ, which are often involved in the morbid action. The disease is usually very stealthy in its mode of invasion, and tardy in its progress, there being commonly an entire absence of the ordinary symptoms of inflammation. The first circumstance, perhaps, that attracts attention is slight impediment in deglutition and breathing, with an inclination to snore, and to sleep with the mouth open. Upon looking into the throat, a tumor is detected, bulging forwards into the fauces, of a reddish, livid, or purplish color, irregular in form, and imparting a distinct sense of fluctuation under pressure of the finger. The matter is of a scrofulous character, and everything about the disease is denotive of this peculiar action. In the advanced stage of the affection, there is often caries of the superior cervical vertebræ, and ulceration of their connecting cartilages. The contents of this variety of abscess occasionally disappear spontaneously, under the influence of sorbefacient remedies, or nature's unassisted efforts; but, in general, they require to be let out artificially, and the sooner this is done the better, as their long retention cannot fail to exert an injurious influence upon the surrounding parts. To perfect the cure, a course of antistrumous treatment should be instituted, and persisted in until the desired object is attained.

A *phlegmonous abscess* sometimes forms in this situation, giving rise to violent local distress, as well as severe constitutional disturbance. It may occur at any period of life, from early infancy to old age. The most common exciting causes are suppression of the cutaneous perspiration; extension of inflammation from the neighboring parts, as the palate and tonsils; erysipelas of the neck and face; disease of the cervical lymphatic glands; stricture of the œsophagus; the lodgment of foreign bodies, as pins, needles, or pieces of bone; and the irritation of decayed teeth. It may also arise spontaneously, during the progress of protracted and exhausting maladies, as measles, scarlatina, typhoid fever, and smallpox.

The symptoms are bold and well marked. The pain is deep-seated and pulsatile, the parts are red and intensely inflamed, the difficulty of swallowing is very great, the breathing is excessively embarrassed, and the patient is unable to lie down. In children, severe convulsions not unfrequently attend. The swelling, which is generally easily seen and felt, is of an ovoidal shape, and quite elastic to the touch, especially in the more advanced stages of the disease. The affections with which it is most liable to be confounded are croup, diphtheria, œdema of the glottis, and abscess of the tonsils. Error is best avoided by a careful inspection of the throat. The proper remedy is a free and early incision. If this be neglected, death from suffocation will be almost inevitable, from the pressure of the matter upon the glottis, or from its sudden escape into the air-passages.

6. *Diphtheritis*.—There is a form of inflammation of the pharynx to which the term pseudo-membranous is applied, as it is characterized by a deposit of corpuscular lymph upon the free surface of the mucous membrane. It is very common in certain localities of Europe, particularly at Paris, where it often prevails as an endemic, sometimes spreading over considerable districts. It is supposed by many to be infectious, inasmuch as it now and then runs through entire families; and is most frequently met with in weakly, ill-fed children, between the second and tenth year. As an accidental disease, it is occasionally noticed in smallpox, scarlatina, measles, and typhoid fever.

The exudation appears either as a continuous membrane, spread over the surface of the pharynx, or in the form of patches, of variable size and shape. However this may be, it is of a grayish, whitish, or pale yellowish color, of a tough consistence, and more or less firmly adherent. It seldom consists of more than one thin layer. When the inflammation is violent, the process frequently extends upwards over the tonsils and palate, downwards into the œsophagus, and forwards into the larynx. Under such circumstances, too, the pseudo-membrane is occasionally of a dirty drab or cineritious appearance, from the admixture of sero-sanguinolent secretion. The deposit is usually preceded, for a day or two, by slight fever, and often extends with great rapidity. The subjacent mucous membrane, which furnishes it, is deeply injected, thickened, and of a scarlet color; in the more severe forms of the malady, it

is softened, ecchymosed, rugose, and ulcerated, the cells lying, perhaps, in immediate contact with the denuded muscular fibres of the part. The mucous follicles are uncommonly large and well developed; the tonsils are softened, tumid, red, and infiltrated with various fluids; and the submaxillary glands and the lymphatic glands of the neck often sympathize in the morbid action.

The treatment of this affection, especially in its endemic forms, is very uncertain, and the consequence is that many of those who are attacked with it die. The most reliable remedies, particularly at the commencement of the disorder, are gentle emetics and purgatives, followed by diaphoretics, and minute doses of calomel. As local applications, the most efficacious are acid nitrate of mercury, hydrochloric acid, and nitrate of silver, all in weak solution, employed twice or thrice in the twenty-four hours. Chlorate of potassa has been a fashionable remedy in the disease, but its effects have seldom been encouraging. Tonics, as quinine and milk punch, are generally required to sustain the strength. Change of air often proves highly beneficial.

7. *Follicular Pharyngitis*.—In long-continued inflammation of the pharynx, the lining membrane of the throat is very prone to assume a granular condition similar to that which occurs on the eyelids in granular conjunctivitis. The disease, which may take place at any period of life, may be specific or non-specific, and is nearly always associated with inflammation of the uvula, palate, and tonsils. The hypertrophied lymph follicles are frequently very numerous and prominent, and the mucous membrane in which they repose is thick, spongy, villous, and of a deep red color. The general health is often materially impaired, and in many cases the patient is harassed with cough and dyspepsia. The diagnosis is always easily determined by a careful inspection of the parts.

In the treatment of follicular pharyngitis special attention should be paid to the nature of the exciting cause and the state of the general health. The most important internal remedies are, blue mass, in alterative doses, mild purgatives, and quinine, either alone, or in union with iron. As a local means, the wet napkin is deserving of particular consideration; it should be worn chiefly at night, and its use should be conjoined with the application, once every third day, at first, of a weak solution of acid nitrate of mercury, and afterwards of solid nitrate of silver. In the intervals, the patient may occasionally gargle the throat with some mildly astringent lotion, or, what is far preferable, use some medicated spray, as a solution of tincture of iron, or alum and tannic acid. When the disease is of a syphilitic character, recourse should be had to iodide of potassium and bichloride of mercury.

8. *Wounds*.—Wounds of the pharynx and Œsophagus, already incidentally treated of elsewhere, are always serious accidents, on account of the importance of the functions of these tubes, and their complicated relations with other structures, which are liable to be injured at the same time. They may be transverse, oblique, or longitudinal, as it respects their direction, and incised, lacerated, contused, or gunshot, as it respects the nature of the vulnerating body. Their existence, which is commonly sufficiently evident, is always, in cases of doubt, easily determined by the escape of ingesta in eating and drinking. Whenever they are accessible, or can be rendered so by a proper enlargement of the external opening, their edges should be approximated by the interrupted suture, carried through the entire thickness of the tube, and placed at intervals not exceeding the fourth of an inch. The ends are tied into a double knot, and cut off close to the surface of the wound, to afford the loops an opportunity of falling into the passage, and thus descending into the stomach. That this is the most certain and rational method of managing these injuries is sufficiently evident from analogy and observation, and it is only surprising that it has hitherto been so seldom adopted.

When the stitching is completed, and the outer wound is closed, the chin should be brought forward upon the sternum by means of bandages carried around the head and underneath the axillæ. The after-treatment should be conducted with the greatest care and attention; inflammation must be kept down by appropriate measures, and the patient must be nourished with the stomach tube.

Occasionally a wound of the pharynx is followed by emphysema of the neck, the air passing from the fauces into the areolar tissue in such a manner as to impart a swollen and hideous appearance to this region. The distension from this cause may be so great as to produce serious impediment to respiration and deglutition, although, in general, the effect is very evanescent, and seldom requires any special treatment.

Another effect, sometimes noticed in wounds of the pharynx, is aphonia. Larrey relates a case in which this accident followed a wound made with a bayonet, the point of which remained, for six weeks, deep in the left side of the pharynx, behind the arch of the palate. On its extraction, which was accomplished with great difficulty, the voice, which had been entirely lost, was instantly restored.

A remarkable case of recovery, after complete division of the pharynx, has been related by Dr. Porter, of New London. The wound, inflicted in an attempt at suicide, was nearly entirely closed at the end of two months, but during the progress of the cure the hyoid bone together with a portion of the epiglottis sloughed away, and the man remained aphonic.

9. *Stricture*.—Of stricture of the œsophagus—for the affection rarely occurs in the pharynx—there are two varieties, the spasmodic, and the organic.

The *spasmodic stricture* of the œsophagus is altogether a very singular disease. It is most common in nervous, excitable girls, soon after the age of puberty, although I have repeatedly witnessed it in very young children of both sexes. Old maids and married women about the decline of the menses are also particularly prone to it. It is produced by a great variety of causes, of which disorder of the uterine functions, derangement of the digestive organs, spinal irritation, and obstruction in and around the tube, as that occasioned by the presence of a foreign body, disease of the larynx, or the pressure of an aneurism, abscess, or enlarged lymphatic glands, are the most common. It is often intimately associated with hysteria, recognizing the same origin, and forming merely, as it were, one of the complications of that Protean affection. Instances occur in which it is produced by the irritation of hemorrhoidal tumors, the removal of which promptly cures the disease. The characteristic symptoms are, severe pain in the œsophagus, or in the œsophagus and pharynx, a sense of constriction in the chest, as if a cord were drawn firmly around it, great difficulty or utter impossibility of swallowing, embarrassment in breathing, and intense mental anxiety, with a feeling of impending suffocation. The attacks often appear suddenly and unexpectedly, and occasionally vanish in the same mysterious manner; their intensity and duration are subject to much diversity, being now mild and short, now severe and protracted. Cases occur in which the disease manifests a periodical tendency, coming and going very much like a paroxysm of intermittent fever.

The treatment of this disease must be regulated according to the nature of the exciting cause, which should, therefore, always be carefully inquired into. Nothing, of course, can be done in the way of permanent relief when it depends upon the pressure of an aneurism of the aorta, or of the innominate or carotid artery, a bulky goitre, or a mass of enlarged lymphatic glands, whether cervical or intrathoracic. When the stricture is caused by an abscess, or the impaction of a foreign body, the remedy is sufficiently obvious, and so also when it is produced by organic disease of the larynx, or by the presence of a polyp in the fauces, pharynx, or œsophagus. In exploring the tube with a view of ascertaining the source of the obstruction, the greatest caution should be used in the passage of bougies and other instruments, lest we lacerate the gullet, or, in case of an overlying aneurism, perforate its sac, and thus occasion instant death.

The general health is, in all cases, amended by suitable means; the bowels are constantly maintained in a soluble condition; the secretions are corrected and restored; spinal irritation is removed by leeches, cupping, and vesication; and proper attention is paid to the diet, exercise, and other hygienic measures. In the purely nervous form of the affection, the patient will be immensely benefited by systematic purgation, by chalybeate tonics, either alone or in union with quinine, by the shower-bath, and by gentle exercise in the open air. Bromide of potassium and chloral combined with tincture of chloride of iron often exercise a most marked influence in arresting the disease. During the attack, relief is attempted by anodynes, assafoetida, valerian, and compound spirit of ether, sinapisms to the spine, the warm bath, and the passage of the probang, which often acts like a charm, almost instantaneously removing the pain and suffering, obviously upon the same principle as the bougie in spasmodic stricture of the urethra. In obstinate cases the parts at the seat of the obstruction are carefully mopped with a weak solution of nitrate of silver, repeated every fourth day. In an instance of spasmodic stricture, the result of laryngeal ulceration, which would not admit of the passage of an instrument, Dr. John Watson, of New York, performed œsophagotomy, and, through the artificial opening thus made, introduced food into the stomach during three months.

Organic stricture of the Œsophagus is uncommon. Although it may occur in any portion of the tube, its most frequent site is just below the cricoid cartilage, or near the junction of the Œsophagus and pharynx, as seen in fig. 427. It is seldom that more than one stricture of this kind is observed in the same person. The immediate cause of the disease is inflammation, whether produced spontaneously, by a syphilitic taint, by external injury, by hot water, or by the contact of acrid substances, as alkalies and acids. Most of the cases that I have met with occurred in subjects under thirty years of age; but it is liable to arise at all periods of life, and is equally common in both sexes. I am not aware that occupation engenders any predisposition to the disease.

The principal seat of the malady in organic stricture of the Œsophagus, is in the lining membrane and the submucous cellular tissue, which are unnaturally hard, firm, resisting, and of a grayish, whitish, or slightly bluish appearance. It is only in the more aggravated cases that there is any serious involvement of the muscular fibres. The contraction may be limited to one side of the tube, or it may include its entire circumference, which, in fact, is most common; in depth it varies from a few lines to several inches. The degree of obstruction ranges from the slightest diminution of the caliber of the tube to almost complete occlusion, as in organic stricture in other mucous canals. The Œsophagus, immediately above the seat of the coarctation, is usually dilated into a kind of subsidiary pouch, which, in severe cases of long standing, is sometimes capable of containing from six to ten ounces of fluid or ingesta. The mucous membrane is generally somewhat attenuated, occasionally opaque and thickened, and, now and then, even ulcerated. The portion of the canal below the stricture is commonly normal.

The *symptoms* of the disease are not, at first, characteristic, as they are merely denotive of impeded deglutition, with a sense of uneasiness in the neck, chest, or precordial region. As it progresses, the patient finds it more and more difficult to swallow both solids and fluids, especially the former, which are often arrested in considerable quantity just above the stricture, from which they either gradually descend into the stomach, or they are at length ejected by vomiting, or, more properly speaking, by regurgitation. Not unfrequently the deglutition is suddenly interrupted by spasm of the part, which compels the patient to desist from further efforts, until the action has subsided. At times, again, he suddenly experiences a sense of suffocation, attended with a feeling of constriction in the chest, palpitation of the heart, and great mental anguish. When the malady is fully established, there is always serious disorder of the digestive apparatus, as flatulence, acid eructations, and constipation; the flesh and strength decline; the countenance has a wan, sallow, pinched appearance; the extremities are habitually cold; the surface is easily impressed by atmospheric vicissitudes; and the poor sufferer, a prey to the worst forebodings, at length dies completely exhausted.

The *diagnosis* of organic stricture can only be determined by a thorough exploration with a bougie, of which one of gum-elastic is the best. In the absence of such an instrument, however, a piece of whalebone, surmounted by a short cylinder of ivory, may be used as a convenient substitute. The head being thrown backwards against the breast of the surgeon, so as to bring the mouth on a line with the fauces, the bougie, well oiled, is carried down to the obstruction, the precise seat of which is thus at once ascertained. To determine its consistence, it is only necessary to note the degree of resistance offered to the passage of the instrument; if this is slight, it may be inferred that the stricture is slight also, and conversely. To obtain a definite idea of its extent, both longitudinal and peripheral, the bougie is carried not only into the stricture, but, if possible, through it.

The *prognosis* is commonly very grave, the disease being always very obstinate and intractable, setting at defiance the best directed efforts of the surgeon for its

Fig. 427.



Stricture of the Gullet, at its most Ordinary Site, with a Bougie passed through it by the Mouth.

relief. In particular is this the case when it has been caused by loss of substance, as a wound, ulceration, or gangrene, or when it has been induced by high inflammation from the contact of an acrid substance, as an alkali or acid. The affection is also, in general, more difficult to cure in the old than in the young, and in such as have been injured by previous disease, intemperance, and other kinds of indulgence, than in those of a healthy, robust constitution.

The *treatment* of this affection is easily understood; for, as it essentially consists in the formation of new tissue elements in the mucous and submucous structures of the œsophagus, the leading indication is to get rid of the new growth, so as to afford the parts an opportunity of regaining their normal caliber, consistence, and resiliency. As a preliminary step, an effort should be made to improve the general health, which is usually considerably disordered, by attention to the diet, bowels, and secretions. When this object has been attained, a gentle course of mercury should be commenced, either in the form of the iodide, mild chloride, or bichloride, the choice of the article being regulated by the peculiar features of the case. Very slight ptyalism is encouraged, and persistently maintained for several weeks. Concurrently with this treatment the bougie, fig. 428, is used, at first once every fourth day, and then

Fig. 428.



œsophageal Probang.

every other day, the instrument being retained a few minutes at each introduction, and its size gradually increased as the stricture yields under the dilating process. Much caution is necessary in both these particulars, lest further formation instead of absorption take place. Cauterization with nitrate of silver may be required when the parts are unusually irritable, but, in general, it should be avoided; it is best performed by means of a probang, surmounted with a very soft piece of sponge, wet with a solution of the salt, varying from ten to thirty grains to the ounce, the operation being repeated at intervals of four or five days, performed in such a manner as to bring the fluid as gently as possible in contact with every portion of the affected surface. In obstinate cases, depending upon the presence of an inordinate quantity of very dense tissue, scarification might be employed, but such a procedure should not be undertaken without great care and deliberation. Special instruments for the performance of internal œsophagotomy, constructed on the same principle as the urethrotome, have been devised and successfully employed by Dolbeau and Trélat. Restoration of caliber being effected, the labor of the patient and surgeon is not ended; on the contrary, vigilant supervision of the general health is steadily maintained, and the insertion of the bougie is repeated at gradually increasing intervals until all danger of relapse is safely passed.

10. *Carcinoma*.—Malignant disease of these tubes usually presents itself in the form of epithelioma, as in fig. 429, commencing as an infiltration in the submucous cellular tissue, and gradually extending to the other structures, especially the mucous. Encephaloid is exceedingly rare, and I am not aware that any example of colloid has ever been met with. The most common site of the heterologous deposit is the œsophagus just behind the larynx, but it may occur in any portion of the canal, and occasionally, although very rarely, it has been known to occupy the pharynx. Old persons are most prone to it, and females suffer more frequently than males. The symptoms are those of dysphagia, attended with pain and a sense of constriction in the chest. Swallowing becomes more and more difficult, and at length even liquids can hardly be forced through the obstruction. The pain is usually of a sharp, pricking, lancinating character, and darts about in different directions, up towards the head and fauces, down towards the stomach, and back towards the spine. The flesh gradually wastes, the countenance exhibits a sallow, cadaverous aspect, obstinate hiccup supervenes, and the patient, worn out by protracted suffering, finally

perishes from inanition. Death usually occurs at a period varying from ten to eighteen months. In some instances life may be destroyed by hemorrhage, from the extension of ulceration to the bloodvessels, as the subclavian, vertebral, and superior intercostal arteries; while occasionally, again, although this also is very rare, the

Fig. 429.



Epithelioma of the Œsophagus.

Fig. 430.



Ulcerated Epithelioma of the Œsophagus.

fatal event is produced by the escape of ingesta into the windpipe, the mediastinum, or the pleural cavity. The causes of carcinoma of the pharynx and œsophagus are similar to those of malignant growths in other parts of the body. The diagnosis may generally be easily determined by the history of the case and by a thorough exploration of the affected parts with the bougie. In the use of this instrument a portion of the tumor is sometimes detached and brought up, and may then be readily subjected to microscopic inspection. The ulcerated form of epithelioma of the œsophagus is well represented in fig. 430, from a specimen in my collection. The tumor was situated near the cardiac extremity of the tube; and the man, who was between thirty-five and forty years of age, finally perished from inanition.

The treatment is, of course, merely palliative. The strength is sustained by nourishing broths, taken by the mouth or rectum, and pain is allayed by anodynes. Great temporary relief, as I have found from repeated trials, may frequently be obtained by the occasional introduction of a bougie or probang, so as to dilate the passage gently at the seat of the obstruction. Indeed, this is the only means of saving the patient from impending starvation; but it is equally true that the irritation produced by the passage of the bougie has a tendency to aggravate the disease. The use of the instrument should never be intrusted to the patient himself, since he may perforate the walls of the tube above the seat of the stricture, or open the aorta or the left bronchus, as occurred in two cases referred to by Billroth in his *Chirurgische Klinik*.

As a means of prolonging life in impermeable stricture of the œsophagus, threatening starvation, *gastrostomy* has attracted considerable attention during the last twenty years, especially in Europe. Sédillot, by whom it was first performed in this affection, Forster, and Sydney Jones have each operated twice, and Fenger, Curling, Durham, and Maury each once; but the results have not been such as to encourage repetition, all the patients having died within a short time after the undertaking, either from exhaustion or peritonitis. But, even supposing that life was not put in immediate jeopardy by the operation, no ultimate good could reasonably be expected from it; for, as the disease of the œsophagus is malignant, death will soon be inevitable, and, hence, the adoption of such a measure would only be a

species of refined cruelty, reflecting no credit upon the surgeon. The only case in which, in my judgment, gastrotomy would be justifiable, is where the stricture has been caused by a scald or burn, or by the contact of some caustic substance, as nitric acid, lye, or potassa, completely destroying the power of deglutition. In one of Mr. Forster's cases the obstruction was due to a caustic alkali, but death from peritonitis ensued on the fourth day.

The only case in which gastrotomy has been performed in this country, on account of obstruction of the œsophagus, was one which occurred in the practice of Dr. F. F. Maury, of this city, in 1869. The patient, a man, twenty-five years old, had formerly suffered from chancre, bubo, and papular eruptions, and was, at the time of the operation, which he survived only seventeen hours, in a state of extreme exhaustion. The stricture, situated near the cardiac extremity of the stomach, was probably of a syphilitic origin.

Should the operation be deemed advisable, it may be executed, according to the method of Sédillot, by making, on the left side of the middle line of the abdomen, about two fingers' breadth from the costal cartilages, and a short distance below the ensiform portion of the sternum, a crucial incision three inches in length, first through the skin, then through the muscles, and lastly through the peritoneum. Inserting the index finger into the wound, the surgeon feels for the left border of the liver, which he takes as a guide to the stomach. The organ is then drawn forward, examined, and carefully stitched, by its anterior surface, to each limb of the cutaneous flap by silver wire, after which a suitable opening is made into it, about midway between its two extremities, and a little above its lower margin. When the consolidation is sufficiently firm, as it will be in three or four days, to prevent the possibility of separation, nutritive injections, in moderate quantities and in as concentrated a form as possible, are introduced, at stated periods, with an appropriate syringe, to sustain life. The wound gradually becomes fistulous, and thus affords ready access, should the patient survive, to the stomach. When the orifice is pretty well cicatrized, a silver tube, provided with two rings, and resembling in shape a shirt button, may be worn to prevent undue contraction.

The line of incision, in this operation, has varied in the hands of different surgeons. Forster, in his first case, made the wound over the left semilunar line, and, in the second, along the outer edge of the straight muscle, in the left hypochondriac region, commencing at the cartilages, and opposite the space between the seventh and eighth ribs. Jones carried his incision vertically downwards from the inner border of the ninth rib. Durham entered the abdomen over the left semilunar line, deeming it best to open the stomach near its greater curvature. Maury made a curvilinear cut, with the convexity towards the linea alba, extending from the sternal extremity of the seventh intercostal space downwards and outwards for nearly four inches, exposing the sheath of the straight muscle, which was then slit up on the grooved director, after which the fibres were separated with the finger and scalpel, and the stomach exposed near the pylorus, as the less movable portion of the organ, and, consequently, the least liable to be disturbed by the walls of the abdomen.

11. *Tumors*.—The pharynx and œsophagus, especially the former, are occasionally, although rarely, the seat of morbid growths, which are, for the most part, of the nature of fibroma, fibrous myoma, fibrous sarcoma, and lipoma. Although any of these neoplasms may exist as distinctly circumscribed masses, they are generally pendulous and pedunculated, or polypoid, the tumor being attached, as the name implies, by a narrow footstalk, sometimes of extraordinary length, while its body, which is usually pyriform, lies loose in the interior of the tube. When situated high up, it is sometimes projected into the fauces, and even into the mouth when the patient coughs or retches, and by this circumstance alone the polypoid may ordinarily be readily distinguished from other forms of morbid growths. Dysphagia, from mechanical obstruction of course exists when the tumor is large, either alone, or, as is more commonly the case, in union with pain, dyspnœa, and suffocative sensations. In a case of polyp of the œsophagus, described by Mr. Arrowsmith, the growth not only filled that tube, but, by passing under the epiglottis, prevented the closure of the larynx, and thus allowed fluids to flow into the trachea in attempts to swallow. A somewhat similar case has been recorded by Mr. Holt. The tumor, which was of a fatty nature, and extended from the pharynx into the œsophagus, was nine inches in length, and was attached to the side of the epiglottis, which it

so completely displaced as to interfere very seriously with the performance of its functions as a safety-valve. When the obstruction produced by such a growth is very great, the patient may, unless relieved by surgical aid, gradually perish from inanition. In the interesting case just described, death was occasioned by suffocation from obstruction of the upper aperture of the larynx.

If the polyp be within reach, it may generally be readily twisted off with the forceps; and a similar proceeding may answer even when it is pretty far down, but in this event it will be necessary to employ a longer instrument, and one that is curved somewhat on the flat; or, instead of this, the growth may be noosed with a silver wire, passed by means of a double canula, and broken off by gentle rotation of the tube, aided by cautious efforts at extraction. Unless their base is very broad, or their seizure very imperfect, few tumors of this kind would be likely to resist such efforts. Failure, however, is possible, and then, provided the polyp is situated in an accessible part of the canal, œsophagotomy may be necessary. Excision of the growth is inadmissible, on account of the subsequent hemorrhage, which it might be very difficult to control.

12. *Paralysis*.—Paralysis of these tubes is sometimes met with, chiefly in old persons affected with palsy in other parts of the body. The characteristic symptom is simply dysphagia, without mechanical obstruction, and, consequently, without any impediment to the passage of the bougie. The disease is usually of unfavorable import, especially when of gradual accession, and the result of organic lesion of the brain, or of the brain and spinal cord. When the attack is sudden, as when the paralysis is induced by apoplexy, or external violence, the danger is not so great, and ultimate recovery may, in many cases, reasonably be expected.

The treatment is regulated by the nature of the exciting cause, and does not, therefore, admit of specific detail. In the more chronic forms, the chief reliance must be upon systematic purgation, gentle but persistent ptyalism, iodide of potassium, strychnia, and counter-irritation of the dorso-cervical portion of the spine, by blister, issue, or moxa. When the strength is much reduced, electricity, the shower-bath, either cold or tepid, the use of the flesh-brush, tonics, and other invigorating measures will be required. Until the œsophagus has regained its muscular powers, the requisite amount of food and drink must be introduced into the stomach by means of an elastic tube.

13. *Foreign Bodies*.—Foreign bodies are liable to lodge upon the root of the tongue, between the arches of the palate, in the mucous follicles of the tonsils, around the mouth of the larynx, in the pharynx, and in the œsophagus. They generally consist of fish and chicken bones, fragments of the kernels of fruit, bits of meat, cartilage, or tendon, pieces of coin, pins, needles, mounted artificial teeth, and other analogous substances. In cleaning the teeth, the bristles of the brush often fall out, and become entangled in the throat. In fact, substances of every form and character are liable to be arrested in these passages, and it is only surprising, when we consider the complex structure of the fauces, that accidents of this kind are not more common. Whatever their nature may be, their presence always awakens great uneasiness, if not actual pain, with a sense of soreness, and a frequent desire to swallow and clear the throat. Occasionally there is a marked increase of the salivary secretion, an abundant flow of ropy mucus, and an alteration of the voice, which is hoarse and guttural. If the foreign body remains for any length of time, inflammation will almost certainly take place, and may run so high as to induce intense distress, if not loss of life.

When the extraneous body is of large size, and impacted in the lower part of the pharynx, or in the upper extremity of the œsophagus, a prominent symptom will be difficulty of breathing from spasm of the glottis. When the pressure is very great, or long continued, suffocation may take place in the same manner as when a foreign substance is lodged in the windpipe. Desault mentions a case in which a woman lost her life in three minutes from asphyxia, occasioned by the impaction of a piece of bone in the middle of the pharynx. Many similar examples are upon record.

Clearance is attempted as early as possible after the accident with the finger, forceps, or emetics, according to the exigencies of the case. If the intruder is within sight, it may often be reached with the finger; or, this failing, it may be extracted with a pair of polyp-forceps, the tongue being previously depressed with an appropriate instrument. When this organ is unsteady, or absolutely rebellious, quietude

is first insured by the inhalation of a moderate quantity of chloroform. Not a little trouble is sometimes experienced in finding the extraneous substance, especially when it is very diminutive, or when it is lodged in one of the mucous follicles of the tonsil, between this body and the arch of the palate, or in a pouch at the root of the tongue. When this is the case, a thorough exploration is made with the finger, aided with a grooved director, a long probe, or a large spoon, with a long, slender handle, with which the parts are pushed gently asunder, and exposed to the light. Should the attempts at extraction fail, relief is sought by emetics, of which the most prompt and efficacious are alum, zinc, copper, and mustard, their action being promoted by large draughts of warm water, during the regurgitation of which the intruder is often safely ejected.

When the patient is unable to swallow on account of the excessive irritation of the œsophagus, or the extraordinary size of the foreign substance, an attempt should be made to convey the emetic into the stomach with a long, narrow, gum-elastic catheter, the extremity of which should, if possible, be quietly insinuated between the wall of the tube and the intruder. In a case reported by Dr. Stabel, of Kreuznach, the injection was promptly followed

by violent emesis and the forcible expulsion of the extraneous body, after a great variety of expedients had been vainly tried to promote extrusion. When the object can not be attained in this manner, vomiting may sometimes be induced by holding a strong solution of tartarized antimony in the mouth.

It is a remarkable circumstance, and one of great practical moment, that, although the foreign body may have been expelled, the irritation awakened by its presence often remains for a considerable time, thus inducing the impression in the mind of the patient that he is still unrelieved. I have repeatedly known this feeling to continue for a number of days, and occasionally, especially in hysterical females, even for several weeks. Moreover, an unpractised finger inserted into the throat may mistake the upper corner of the hyoid bone for the body supposed to have been swallowed.

When the foreign body is lodged in the œsophagus, or in the inferior part of the pharynx, extrusion is often readily effected with a pair of long, slender gullet-forceps, such, for example as that represented in fig. 431, invented by Dr. Bond, of this city. These forceps, besides being very light and curved, are bevelled off at the edges, an arrangement which effectually

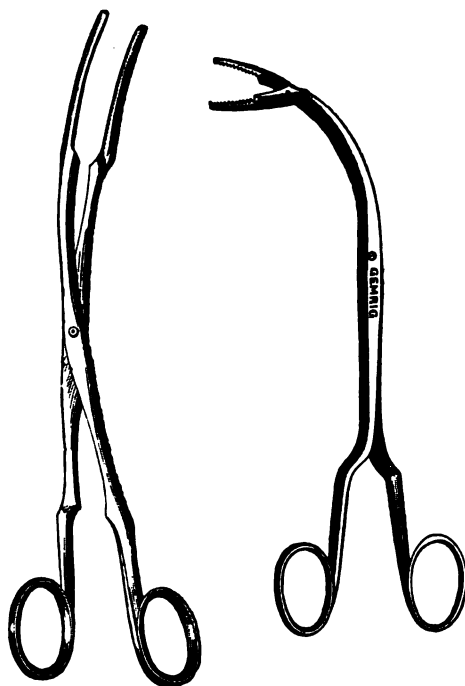
prevents them from seizing and pinching the mucous membrane, an occurrence so liable to happen in the use of the ordinary instrument. Moreover, it admirably fits them for withdrawing needles, pins, and other sharp-pointed bodies, which, while they are firmly held by the blades, fall into the groove at their sides, and thus slide along the passage without seriously injuring its walls.

An excellent instrument, in some respects superior to that of Dr. Bond, is delineated in fig. 432. It is so constructed that a gentle movement of the thumb and index finger causes the blades to open and shut antero-posteriorly, while the rest of the instrument remains apparently motionless.

In performing the operation, the patient sits upon a low stool, with his head thrown backwards against the breast of the surgeon. The instrument, well oiled and warmed, is then passed down into the tube, and used as a searcher; as soon as it is brought in contact with the extraneous substance, its blades are expanded over

Fig. 431.

Fig. 432.



Œsophageal Forceps.

it, and extraction effected in as gentle a manner as possible. Generally no after-treatment is required.

Occasionally a blunt hook is used for effecting extraction. It is carried down in the same manner as the gullet-forceps, if possible, beneath the foreign body, which is then seized and drawn up. Pieces of coin, pins, and bits of bone are sometimes readily removed in this way. A very singular case, in which an operation of this kind proved fatal, occurred many years ago at Cincinnati. A female having, as she supposed, swallowed a pin, a practitioner endeavored to extract it by means of a common dress-hook, secured to the end of a piece of whalebone. In his attempt to withdraw it, the hook became fastened in the œsophagus, the walls of which were severely lacerated. Violent inflammation ensued, followed in a few days by the death of the patient. The late Professor Cobb, who used to have the preparation in his private cabinet, made the dissection, and discovered, immediately below the larynx, a rent upwards of an inch and a quarter in length. No pin was found, and the probability was that none had ever been swallowed!

An excellent instrument for extracting foreign bodies from the œsophagus is represented in fig. 433. It was constructed at my suggestion, by Mr. Kolbé, and consists of a steel rod, about fifteen inches long, inclosing a stilet, surmounted by four wing-like processes, which may be shut or expanded at pleasure, simply by turning the handle. Another convenient contrivance, tipped with horsehairs and acting upon similar principles, is exhibited in fig. 434. Pins, needles, and other slender substances, may sometimes be entangled in the loops formed by tying a number of horsehairs to the extremity of a piece of whalebone.

When the substance is of a digestible nature, as a piece of bread, potato, or beef, and cannot be readily extracted, it should be pushed down into the stomach by means of a probang, an instrument consisting of a stout whalebone rod, surmounted by a piece of sponge. The operation, which should be performed with great gentleness, the patient sitting on a chair, with the head inclined backwards, is not always so easy as might be imagined. Many years ago I attended a man, in the inferior part of whose œsophagus a large piece of veal had lodged, where it produced excessive irritation and so much spasmodic action as to render it extremely difficult to force it into the stomach. For several hours his embarrassment of breathing and thoracic distress were most intense.

A foreign body, as a fish or chicken bone, may occasionally be rendered so flexible by the action of an acid as to enable the surgeon to effect its displacement by an instrument, a morsel of bread, or an emetic. In a case of this kind under the care of Professor Hall, of Baltimore, the plan succeeded perfectly after vomiting, the probang, and forceps had been tried in vain. The acid may be common vinegar, or, what is better, nitric acid, diluted in such a manner as not to injure the mucous membrane of the œsophagus.

A curious instance has been recorded by Dr. Bright, of Kentucky, in which a fish hook along with a piece of the line, lodged in the œsophagus, was extracted by means of a bullet, perforated at the middle, and allowed to fall forcibly against the foreign substance. In this way the point of the hook was disengaged from the mucous membrane, and withdrawal effected without injury to the tube.

A case in which a live fish, from four to five inches in length, and one inch thick, exclusive of the sharp dorsal fin, was impacted for a number of hours in a man's œsophagus, has been reported by Dr. Stewart, of Rangoon. As the animal could not be extracted, it was pushed by means of a probang into the stomach, with speedy relief of the severe distress it had occasioned.

When a foreign substance, especially if it is rough, sharp, or angular, is retained

Fig. 433.

Fig. 434.



Fig. 433. Instrument for Extracting Foreign Bodies from the Œsophagus. Fig. 434. Horsehair Probang.

for any length of time in the gullet, it may occasion serious inflammation, followed by abscess, gangrene, ulceration, or even loss of life. Dorsey has related an instance in which a youth of seventeen suddenly perished from a copious hemorrhage of the œsophagus, induced by the long-continued lodgment of an English farthing. Needles, pins, and bits of bone, after having sojourned for a while in the œsophagus or pharynx, often descend into the stomach, and are ultimately voided by the bowels; or, instead of this, they perforate the coats of these tubes, and travel over different parts of the body, being, perhaps, at length eliminated through the skin; or, finally, they enter the thoracic cavity, and produce destructive inflammation of its contents. Mr. Kirby, of Dublin, has related the case of a woman who bled to death from injury sustained by the right subclavian artery, from a piece of bone which had perforated the œsophagus, behind which the vessel lay in its anomalous course from the arch of the aorta towards the right side of the trunk; and Dr. Duncan, of Edinburgh, met with an instance in which the aorta itself was opened by the sharp points of the metallic setting of some artificial teeth arrested in the tube. In a case observed by Dr. J. W. Ogle, of London, a piece of bone, lodged in the œsophagus, caused fatal disease of the spinal cord. On the other hand a large body may sometimes remain impacted in the tube for a long time with little suffering. Thus, Dr. Robert Jackson, of Leith, attended a woman, forty-two years of age, who lived for nearly two months, part of the time in comparative ease, with a large key, upwards of four inches in length, in the gullet. The handle of the key in its descent had caught in a fold of mucous membrane, and destroyed the coats of the tube opposite the lower part of the larynx.

When a foreign body has been for a long time impacted in the œsophagus, it is occasionally so completely buried in the walls of this tube as to elude the contact of the probe, bougie, or probang employed for its detection, the instrument rapidly passing on into the stomach as if there were no obstacle. A knowledge of this fact should put the surgeon upon his guard in respect to his diagnosis. A number of instances have been recorded in which, although all the rational symptoms existed, substances of large size, concealed in this way, were not discovered until after death.

14. *Œsophagotomy*.—I have never performed œsophagotomy, and such an operation will, I presume, rarely, if ever, be required, if a proper direction be given to our attempts at extrusion. It is only when the foreign body is immovably fixed in its position that the question should be at all entertained. Should the operation be decided on, it may be executed in the following manner: The neck being stretched, and the head retracted, an incision, beginning opposite the upper border of the thyroid cartilage and midway between it and the sterno-mastoid muscle, is extended for three or four inches down the neck, parallel with the muscle and on the side in which the foreign substance is most prominent. By successive touches with the knife and director, the carotid sheath is exposed, which is then drawn outwards with a retractor, while the larynx and trachea, along with the omo-hyoid, sterno-hyoid, and sterno-thyroid muscles and the thyroid gland, are drawn inwards, care being taken to avoid injury to the inferior thyroid artery and the recurrent laryngeal nerve. The tube being thus exposed, its wall is divided to the requisite extent, on the foreign body, or, if this cannot be felt, on a bougie passed through the mouth, and the substance, whatever it may be, is extracted with the finger or forceps, as may be found most convenient. As soon as clearance has been effected, and the bleeding arrested, the edges of the œsophageal wound are neatly approximated by several points of the interrupted suture, made with very fine, but strong silk, the ends being cut off close to the knots, to afford the ligatures an opportunity of dropping ultimately into the interior of the passage. The cutaneous wound is dressed in the usual manner, and the case is afterwards managed upon general principles, the patient being supported during the first fortnight with strong meat soup, conveyed by means of a tube into the stomach, or, what will be better, introduced into the rectum.

In order to facilitate the execution of this operation, especially when there is no tumor in the neck, Vacca Berlinghieri has devised an instrument to serve as a guide to the knife. It simply consists of a contrivance shaped like a catheter, curved at the distal extremity, and furnished with a groove, from which, when the instrument has been passed into the œsophagus, a stylet is made to project so as to lift up the wall of the tube, and render its incision more easy.

Œsophagotomy for the extraction of foreign bodies was first practised by Gour-

sault in 1738; and upwards of three quarters of a century elapsed before it was repeated. Of 24 cases analyzed by Dr. David W. Cheever, of Boston, in 1870, including three of his own, 20 recovered, and 4 died, the fatal result being due in one to gangrene of the pharynx, in two to abscess, and in one to pneumonia, existing at the time of the operation. In three of the cases, which are included in the recoveries, no foreign body was found. These flattering results place œsophagotomy in a very favorable light, and will no doubt go far in removing the apprehensions so generally entertained in regard to the propriety of its execution. When all reasonable attempts at extraction have failed, the best plan is at once to use the knife, otherwise very serious complications may arise, and thus materially compromise the safety of the patient.

15. *Passage of Tubes along the Œsophagus.*—The practitioner is sometimes obliged to insert tubes into the stomach for washing out its contents, as in poisoning, or for injecting food into the organ with a view of sustaining life, as in disease of the pharynx and œsophagus. In the former case, the addition of a pump is necessary; in the latter, a gum-elastic bottle. The tubes for either of these purposes should be at least eighteen inches in length, and from four to six lines in diameter. The patient being seated upon a chair, with his head reclining against the breast of an assistant, the instrument, carefully oiled, is cautiously conducted down into the pharynx, and thence along the œsophagus into the stomach. If poison is present, tepid water is now injected, and immediately after withdrawn with the pump, although not the whole of it, lest the mucous membrane of the stomach be sucked into the holes of the tube, and so torn into shreds. The operation is repeated until thorough clearance is effected, or until the fluid returns colorless, the quantity thrown in at each time varying from a pint to a quart, according to the age of the patient and the circumstances of the case. When the tube is inserted for the purpose of injecting nutriment, the liquid should be introduced very slowly, so as not to occasion sudden and painful distension.

It seems difficult to believe that such an instrument could be passed into the windpipe instead of the œsophagus, and yet, judging from the cautious manner in which writers lay down their instructions for its introduction, we are forced to conclude that such an occurrence is not only possible, but occasionally quite probable. The accident would, it may be presumed, be most likely to happen when the patient is in a state of deep coma or partial asphyxia, thus preventing him from perceiving the contact of the instrument. It has been proposed, in such an event, to hold a lighted taper before the tube, on the assumption that, if it be extinguished, it is to be regarded as an evidence that the instrument is in the windpipe, and conversely. But such a procedure is altogether unsatisfactory, and the only safe plan, at last, for the surgeon, is to rely upon his knowledge of anatomy, and his manual dexterity. The very facility with which the tube glides along may be taken as an evidence that it is descending the œsophagus.

CHAPTER XIV.

HERNIA.

SECT. I.—GENERAL OBSERVATIONS.

By the term hernia, as used at the present day, is understood a protrusion of any of the abdominal viscera through a natural or accidental aperture in the abdominal walls, accompanied by a process of the peritoneum, and invested by the common integument. The parts most liable to this occurrence are the intestines, especially the small, and the omentum. Of the small bowels, the portions most generally concerned in the descent are the ileum and the inferior third of the jejunum. The duodenum is too fixed in its situation to admit of such an accident. The arch and sigmoid flexure of the colon occasionally pass out of the abdomen, and the same fate is sometimes, although rarely, experienced by the cæcum and vermiform appendix. Now and then an instance occurs in which a portion of the stomach, liver, spleen,

or urinary bladder forms a constituent of the hernia. Cases are also witnessed in which the ovaries, the Fallopian tubes, and even the uterus are protruded. The rectum has occasionally been found included in an ischiatic hernia.

Various terms are employed to designate such a tumor, derived either from the nature of its contents, the particular condition of the included structures, or the region of the body in which it occurs. Thus, when the protrusion consists of intestine alone, it is called an enterocele; epiplocele, when it is composed merely of omentum; and entero-epiplocele, when it consists both of intestine and omentum. A hernia is said to be reducible when its contents can readily be returned into the peritoneal cavity; irreducible, when they remain permanently fixed in their abnormal situation; and strangulated, when they are confined by a stricture, or compressed by the edges of the aperture at which they emerged. The term incarcerated is used to denote the temporary sojourn of the parts in their extramural situation, without any obstruction to the passage of the feces, and the existence of inflammatory symptoms. The words inguinal, scrotal, femoral, umbilical, ischiatic, obturator, and labial, have reference to the particular regions in which the descent takes place. A rupture sometimes occurs at birth, and it is then said to be congenital. Finally, a hernia may be recent or old, complete or incomplete, single or double.

The frequency of hernia cannot be correctly estimated, nor is this a matter of any particular practical moment. It doubtless differs in different countries, in different occupations, and in different classes of society; the poor being much more obnoxious to it than the rich. The affection occurs at all periods of life. Quite frequently, indeed, it is congenital.

An idea of the influence of age upon the production of hernia may be formed from the following table, founded upon 77,997 cases reported by the London Truss Society:—

YEARS.	CASES.	YEARS.	CASES.
From 1 to 10	7,229	From 50 to 60	14,169
" 10 " 20	4,551	" 60 " 70	9,701
" 20 " 30	8,715	" 70 " 80	8,866
" 30 " 40	13,614	" 80 " 90	443
" 40 " 50	15,027	" 90 " 100	23

Men suffer from hernia much more frequently than women, in the proportion probably of about four and a half to one. Thus, out of 83,584 patients relieved by the London Truss Society, 67,798 were males, and 15,786 were females.

These differences are probably mainly, if not entirely, due simply to differences of occupation and consequent muscular exertion. Men are most frequently affected with inguinal hernia, women with femoral and umbilical; the differences depending either upon anatomical causes, or physical confirmation.

Causes.—The causes of hernia are usually divided into predisposing and exciting. Among the former the principal are, inordinate size of the normal outlets of the abdomen, and the existence of preternatural apertures, from defective development of the walls of this cavity. Under the same head may be included unusual laxity of the muscles and tendons of the abdomen. Distension of the abdomen by pregnancy, ascites, obesity, and different kinds of tumors also favors the formation of hernia. The same is true of tight lacing, mechanical obstruction to the evacuation of the urine, chronic disease of the lower bowel, and general debility, whether natural or acquired.

The most common exciting cause of the disease is inordinate contraction of the diaphragm, pushing the abdominal viscera forcibly against their walls, at a time when these walls themselves are in a state of excessive tension. The contained and containing structures being thus made to act and react upon each other, the floating parts of the former are often readily thrust across the resisting parts of the latter. Hence, hernia is most generally produced in straining at stool, in difficult parturition, lifting heavy weights, playing on wind instruments, jumping, running, vomiting, and coughing. Occasionally the occurrence is the immediate result of external violence, as a blow or wound, separating or severing some of the component structures of the walls of the abdomen.

Wounds of the abdomen are a frequent cause of hernia. The culpable manner in which these lesions are generally treated can hardly fail to be followed by protrusion of the viscera. The puncture made in paracentesis has occasionally given rise to

hernia. Many years ago a remarkable case of this kind occurred in this city, in a lady who was tapped by an eminent practitioner, under the supposition that she had ascites. It turned out, however, that she was merely in an advanced stage of pregnancy. The operation brought on premature delivery, followed soon after by ventral hernia, which, increasing in volume, became at length quite troublesome, the more so, as it was subject to occasional attacks of strangulation, in one of which the woman lost her life.

Anatomy.—Every hernia has, besides a certain number of other coverings, a distinct sac, a mouth, a neck, and a body. Each of these parts is of sufficient importance to require separate consideration.

The *sac* forms the immediate investment of the protruded parts, and is of a serous nature, being, in fact, merely a prolongation of the parietal portion of the peritoneum, pushed down during their descent. It varies much in structure, as well as in size and shape. In the earlier stages of hernia, it generally retains both its normal transparency and tenuity; but in cases of long standing, and particularly in those of large bulk, it is almost always considerably thickened, opaque, dense, and even fibrous; its free surface is rough, corrugated, discolored, and often incrustated with lymph; and the surrounding cellular substance, which is frequently separable into several layers, is commonly indurated, and occasionally loaded with fatty matter. Serum sometimes accumulates in considerable quantity in the sac, constituting a species of veritable dropsy. These changes are, of course, the direct product of the inflammatory action which the sac experiences during the progress of the disease. The sac also admits of great extension, as is shown in certain forms of scrotal hernia, in which the tumor descends nearly as low as the knee. Sometimes the sac, instead of being thickened, is remarkably attenuated, or very thin at one point and thickened at another; occasionally, again, cases are witnessed in which it has given way, either by absorption or laceration. It is also to be remembered that there are certain varieties of hernia in which the protruded parts receive only a partial investment of this kind. This is uniformly the case in hernia of the cæcum and bladder, which are but imperfectly covered by peritoneum in the natural state. A rupture following upon a wound is always destitute of a proper sac.

The *size* of the sac varies from a pigeon's egg to that of an adult's head. In general, it may be assumed that the younger a rupture is the smaller will be the sac, and conversely. It has already been stated that, in scrotal hernia, the tumor occasionally reaches nearly as low down as the knee. Its shape, which is liable to endless diversity, may be globular, pyriform, conical, cylindrical, or hemispherical; occasionally it has a constricted, hour-glass arrangement, or it consists of alternate dilatations and contractions. The annexed drawing, fig. 435, from a preparation in my collection, affords a good illustration of the more common shape of the hernial sac.

The *number* of sacs is variable. In recent cases, there is rarely, if ever, more than one. In very old, on the contrary, several sometimes occur together; and in an instance recorded by Sir Astley Cooper there were as many as six, three on each side, all internal to the epigastric artery.

The other investments of the tumor vary in number, as well as in character, in the several regions in which they are situated, and will be described along with the different varieties of hernia. Meanwhile, it may be remarked that every rupture has a tegumentary envelop, consisting of skin and cellular tissue, either in their natural state, or variously altered by the pressure of the protruded parts. Muscular fibres seldom form a distinct tunic in any of the varieties of the affection.

The *mouth* of the hernia is that portion of the tumor which forms the communication between the sac above described and the general peritoneal cavity. In its shape it generally resembles an elongated fissure, but in some instances, especially in old and bulky ruptures, it is nearly circular. Its size varies from that of a small

Fig. 435.



Hernial Sac, with its Mouth, Neck, Body, and Fundus.

aperture to that of an opening capable of admitting a large fist. Two or more sacs have been known to communicate with the abdomen by a common mouth.

The *neck* of the hernia lies just below its mouth, being the narrow, constricted portion, embraced by the edges of the natural or accidental orifice at which the descent takes place. These boundaries are formed either by muscular, tendinous, or aponeurotic fibres, and, from the character which they play in the production of strangulation, deserve to be studied with the greatest care and attention.

The *base* of the hernia is its lower extremity, and the *body* that portion which lies between the base and the neck.

When the contents of a hernia are prevented from protruding, the neck of the sac has a remarkable disposition to close, and to destroy, either partly or completely, the communication between it and the general peritoneal cavity. In time the whole sac may be obliterated, or, as more frequently happens, it remains, and becomes filled with water, forming a tumor similar to a hydrocele of the vaginal tunic of the testicle. By the side of this tumor another protrusion may afterwards occur, the viscera passing through the same orifice, and pushing down before them a fresh process of peritoneum.

These old sacs are sometimes a source of much embarrassment to the surgeon in operating for the relief of strangulated hernia, from the fact that they overlap the protruded viscera, and thus serve to mask the parts. The difficulty is greatly increased when, as occasionally happens, the contents of the tumor, from an extension of the inflammation, assume a bloody character.

The *volume* of a hernia, however constituted, is liable to so much diversity as hardly to admit of any definite statement. Generally speaking, it may be assumed that the more recent a rupture is the smaller will be its bulk, and conversely; but this law has many exceptions, as is shown, for example, in cases of hernia consequent upon severe muscular exertion and external injury, as a laceration or division of the walls of the abdomen, in which such a protrusion often has a large bulk at the very moment of its occurrence. There are also regional differences in regard to the size of these tumors. Thus, a femoral hernia is always, other things being equal, much smaller than an inguinal hernia, its size rarely exceeding that of a pigeon's egg, or an almond. The largest tumors of this kind are generally old scrotal and umbilical ruptures.

The amount of protruded structures is generally in direct proportion to the size of the tumor. In enterocoele the contents of the hernia may consist nearly of the whole of the floating portion of the bowel, of a small loop, or of a part merely of the circumference of the tube; too small, perhaps, to form the slightest appreciable swelling upon the external surface. Large quantities of the omentum also sometimes descend, but in most cases the protrusion is small.

The changes which the protruded structures undergo should not be overlooked, as they exert an important influence upon the condition of the rupture, especially in strangulation. In a hernia of recent standing the parts, as might be supposed, retain, in great degree, if not entirely, their normal appearance; but it is very different in old cases. Here the parts from the pressure to which they are incessantly exposed, gradually become opaque, indurated, thickened, and altered in shape, so that, eventually, they are rendered either irreducible or are replaced with great difficulty. The changes are generally much more conspicuous in the omentum than in the intestine, the former of which is often enormously hypertrophied, either by interstitial deposits of plasma, or, as is more generally the case, by an accumulation of fat within its layers. Instances occur in which, from this cause, the omentum is from half an inch to an inch in thickness, at the same time that it, perhaps, exhibits a remarkably tuberculated appearance, not unlike the surface of a pudding stone. These changes are commonly most prominent in the lower part of the sac, and in old ruptures of fat persons.

In an entero-epiplocele the omentum occasionally completely envelops the intestine, and may thus become a cause of strangulation requiring the greatest care on the part of the surgeon to prevent injury of the vessel in the division of the stricture. In other cases, again, the omentum forms a distinct bag, in which the protruded bowel is permanently imprisoned. Sacs of this kind have been observed in all the more common varieties of hernia, but are particularly liable to occur in umbilical ruptures, owing to the fact that the omentum always enters so largely into their composition. Once formed, these sacs are capable of acquiring an enormous size, as in

a case recorded by Mr. Prescott Hewett, in which it was six inches in length by eleven inches in circumference at its widest part. The abnormal pouch, in old ruptures, is usually more or less firmly adherent to the proper hernial sac, on the one hand, and to the bowel, on the other.

I. REDUCIBLE HERNIA.

The symptoms of reducible hernia are greatly influenced by the nature of the protruded structures. An *enterocele* is soft and elastic; smooth, or nearly smooth, on the surface; free from pain and soreness; and of a globular, ovoidal, or conical figure. It imparts a distinct impulse to the finger when the patient coughs; has a gaseous feel; often emits a clear sound on percussion; disappears during recumbency, and immediately recurs on the resumption of the erect posture. The reduction is generally effected suddenly and in mass, with a gurgling, rumbling, or explosive noise. When the bowel, however, contains much solid matter, the tumor may be hard, unequal, nearly inelastic, and return lazily and almost noiselessly. The size of an *enterocele* is often considerably influenced by the condition of the alimentary canal; being smaller after fasting and the use of purgatives, and larger when the tube is distended with food, gas, or fecal matter.

In *epiplocele*, the tumor is of a more irregular figure, and of a flabby, doughy consistence, very different from that which characterizes an *enterocele*; it emits no sound on percussion; imparts no impulse on coughing; is free from tension; does not expand or diminish during the repletion or vacuity of the alimentary tube; and is always reduced with more difficulty than a protruded bowel. Omental, like intestinal, hernia, may occur at any period of life, but is more frequent in elderly than in young subjects. A double omental hernia is sometimes met with. I have seen examples of it both in the inguinal and femoral regions.

In an *entero-epiplocele* the symptoms are of a mixed nature, and the diagnosis is, therefore, often more obscure than in the other forms of the protrusion. If one part of the tumor feel soft, elastic, and gaseous, and the other doughy, heavy, and nearly incompressible; or if one portion slip up quickly and with a gurgling noise, and the other remain stationary, or is less easily replaced, the presumption is that it contains both intestine and omentum. Frequently, however, the characteristic symptoms are absent, and the true nature of the swelling can only be determined by the knife.

When the stomach protrudes, the tumor enlarges during eating and diminishes when the stomach is empty; in the former case, it is dull on percussion, in the latter more or less resonant and elastic. The median situation of the tumor is of some value in a diagnostic point of view.

A hernia in which the cæcum is confined is generally of slow formation, commencing in the right iliac region, and gradually descending towards the external ring, in the course of the inguinal canal; small at first, and larger afterwards; reducible with difficulty, if at all, and often nodulated upon the surface from the impaction of indurated fecal matter.

When the sigmoid flexure of the colon is included in the rupture, the descent usually follows the course of the spermatic cord. In rare cases, it passes out immediately behind the external inguinal ring, and instances occur in which it forms the principal constituent of a ventral hernia. Like the cæcum, it may present either directly by its posterior surface, or through the medium of its short and imperfect mesentery.

A hernia in which the bladder is the protruding part is generally easily distinguished by its gradual formation, by its fluctuation, and by its increased bulk when the bladder is distended, followed by the effacement of the tumor after micturition. A resort to the catheter, however, is the most certain means of discrimination. Although *cystocele*, as this hernia is usually termed, is most common in perineal and vaginal ruptures, it has also been found in the inguinal, femoral, and ventral varieties. In old cases, attended with great bulk, the tumor sometimes exists on both sides.

A rupture containing a portion of the liver, or spleen, the ovary, the uterus, or a floating kidney, is distinguished by its solid feel, by its tardy increase, and by the uniformity of its consistence.

A reducible hernia, unless very large, is rarely attended with any decided derangement of the general health. Very commonly, indeed, all the functions of the body

are well performed. When the disease becomes troublesome, the symptoms usually complained of are, indigestion, flatulence, eructations, colic, constipation, and painful, dragging sensations in the abdomen. The patient, in recent cases, is generally able to move about, and attend to business, without any particular suffering or inconvenience even when he does not wear a truss. I have known persons affected with inguinal hernia live in great comfort for years without any mechanical support whatever.

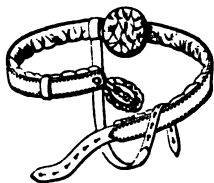
Treatment.—For the reducible hernia, the best remedy is a suitable truss, an instrument designed to answer the purpose of a retentive apparatus. It should be applied as soon as the true nature of the disease has been determined, and worn uninterruptedly until there is reason to believe that the opening of descent has become effectually and permanently closed. Even when this object cannot be expected to be attained, on account of the great size of the aperture, the long standing of the case, or the advanced age of the patient, the viscera should be constantly maintained in their natural position, lest, in an unguarded moment, or in consequence of sudden and violent muscular exertion, recurrence of the rupture should take place, and the protruded parts be strangulated. When the instrument cannot be worn at night, it should always be replaced in the morning before the patient rises, the surface upon which the principal pressure is applied being previously well washed with soap and water, and then rubbed with alcohol, a solution of alum, or some spirituous lotion. Unless these precautions are properly attended to, the skin will be liable to become chafed and covered with boils.

There is no period of life, except that of early infancy, in which a truss, if properly constructed and adjusted, may not be worn with advantage, if not with a prospect of ultimate cure. The only objection to the use of such an instrument in very young children, is its liability to chafe the skin, and to become soiled by the excretions, thus imposing a great deal of care and anxiety upon their attendants.

The *trusses* of the present day are, in every respect, very superior to those in use even a quarter of a century ago. The instruments invented by Stagner and Hood, of Kentucky, and afterwards improved by Chase, Dodson, Sheldon, and others, are nearly as perfect as it is possible to make such contrivances. They combine great cheapness and finish with extraordinary lightness and efficiency, and are every way worthy of the favor which they have received in this country and in Europe. The substitution of the wooden block for the soft pads, formerly in vogue, was one of the most valuable additions to the mechanical surgery of the present century. With the old instrument it was not only frequently difficult to maintain the reduction of the hernia, but such a thing as a radical cure was hardly ever even thought of. The American truss, on the contrary, while it most effectually answers the purpose of a retentive apparatus, often, by the steady, gentle, and uniform pressure of its block, permanently cures the disease.

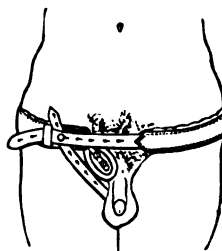
The truss of Stagner and Hood, improved by Chase and others, is represented in fig. 436. The block, composed of beech, cedar, or boxwood, is of a semiovoidal shape, convex on its abdominal surface, and flat externally; it is placed more or less obliquely, and is so arranged, in regard to the spring, as to admit of being moved,

Fig. 436.



Truss.

Fig. 437.



Truss Applied.

in order to adapt it more accurately to the part and body. Its great advantages are its uniform consistence and smoothness, its durability, and its inability to imbibe perspiration; qualities which are nearly all wanting in the pads of the older instruments, as well as in many of the modern. The spring consists of a light but strong

of steel, capable of encircling about two-thirds of the body, very flexible and elastic, and thoroughly covered to prevent it from chafing the skin. The leather which surrounds the spring terminates in a free extremity, pierced with numerous apertures for fastening it, at the other end of the instrument, to a screw just beyond the lock. To prevent the truss from slipping up over the hips, a thigh-strap, also padded, is attached to it. The adjoining cut, fig. 437, represents the instrument applied to the body.

The number of trusses before the profession is immense; a large volume would hardly suffice to describe and delineate them. The principal differences among them are due to the nature, form, and arrangement of the pad, which, consisting of wood, metal, glass, lead, India-rubber, or wire, may be circular, oval, oblong, triangular, hexagonal, or cup-shaped. In Marsh's instrument, the pad is composed of half a dozen small, oblong balls, forming a kind of ring. In the Maidstone truss, which has been used as a model for many of these modern contrivances, the pad slides on the spring, so as to allow the instrument to adapt itself to the varying movements of the body. In the truss of Salmon and Ody, the pad revolves on a ball and socket. That of Edwards, it both slides and revolves; and a somewhat similar arrangement exists in the truss of Dr. Sheldon, of New York, which has two pads, both of which, one semilunar and the other cylindrical, the latter resting partially in the concave margin of the former, thus admitting of more concentrated pressure. Sometimes the pad is filled with air, sand, or hair. The body piece of the instrument also varies a good deal. Thus, the spring occasionally extends entirely around the hips, or, instead of a spring, there is a round wire, as in Newson's truss, or a simple belt, as in the Moc Main truss, or an elastic India-rubber band, as in Lejeune's.

The most elegant truss at present manufactured in this country is that of Dr. Sheldon, the inguinal variety of which is represented in fig. 438. The pad, made of wood, is of a semicircular shape, and is covered with an oblong compress, composed of the same material, but much smaller, and so arranged as to bear upon the inguinal canal, while the pad itself supports the abdomen above.

The spring of the instrument does not differ essentially from that of the more ordinary truss.

It is hardly possible for a person to obtain a well-fitting truss without direct consultation with the manufacturer. This is a matter which is unfortunately, too much neglected, the patient too often thinking that he can effect for himself what he ought always to do himself. When the proper examination cannot be made by the cutler, the measure of the body around the hips should be carefully taken with a piece of annealed wire, with an account of the particular form of the rupture, an inch to an inch and a half being allowed for the padding.

Every person having hernia should have two instruments of this kind, so that, in event of accident, he may not be obliged to be without a truss while the broken one is undergoing repair. For want of this precaution, patients have occasionally incurred great risk of life.

For very young children the most suitable retentive apparatus is an India-rubber band and pad, without a spring. Special attention must be paid to cleanliness, and, when the little patient has attained the age of eight, ten, or twelve weeks, he will generally be able to wear an ordinary truss, provided the spring is not too strong, there are two pads in front and one very broad one behind to grasp the back. The common opinion is that very young children cannot wear a truss to advantage, experience has shown this to be a mistake.

The chances of a radical cure by the use of a truss are, other things being equal, less greater in proportion to the small size and recent standing of the hernia, the absence of obesity, and the youth of the patient. When the tumor is large, the probability of effecting the obliteration of the abdominal aperture will be comparatively slight, on account of the difficulty of procuring an adequate supply of plastic

Fig. 438.



Sheldon's Truss.

matter, and hence few such cases ever thoroughly recover. Under opposite circumstances, on the contrary, the opening is often closed in a short time, for then the parts are more easily influenced by adhesive inflammation, which the steady and persistent pressure of the instrument has a tendency to excite. The sooner, therefore, a truss is applied, the better it fits, and the more steadily it is worn, the greater will be the chances of a speedy and permanent cure. Yet the fact that a rupture is old and bulky should not prevent the use of such an expedient, provided the parts are still reducible; for the efforts of the surgeon are occasionally crowned with success in cases apparently the most unpromising. Should no radical cure follow, the patient will lose nothing by the attempt; on the contrary, he will be a decided gainer, inasmuch as the tumor will not only not increase under such management, but will be effectually guarded against strangulation. Some difference in respect to the curability of hernia occurs as this complaint manifests itself in different regions of the abdomen. Thus, an inguinal hernia is always more easily relieved than a femoral, umbilical, or scrotal, for the reason, doubtless, that the structures through which the descent takes place are more easily compressed, and, therefore, more easily influenced by exudative inflammation. In young subjects, the probability is that the obliteration of the abdominal aperture is materially promoted by the natural tendency which its margins have to contract. In no instance, perhaps, is there much effusion of plastic matter; certainly much less than is generally supposed. The importance, therefore, of giving early and efficient support, not only to the parts immediately interested in the protrusion, but to the whole abdomen, must at once be obvious, and should receive due attention in every case where the object is to bring about such a result. The efficiency of the truss, in promoting the radical cure of hernia, may be greatly increased, in almost every case, by the use of an abdominal supporter, constructed upon the principle of the instrument employed by women in displacement of the uterus. The weight of the abdominal viscera being thus measurably taken off from the inguinal rings, retention of the bowel is not only much more easily effected, but the edges of the rings are not so likely to be separated, and the adhesions, consequent upon the wearing of the truss, broken up.

Various methods, besides the truss, have been suggested for promoting the radical cure of hernia; of these, some date back to a remote period of the profession, and partake largely of the rude nature which characterized the practice of the older surgeons. To this category belong the operations of excision of the sac, the exposure of the sac and the application of the ligature to its neck, and the incision of the sac and the use of irritants for the purpose of inducing its obliteration; all of which resulted not only in much suffering, but in the loss of many lives. What surprises one is, not that these operations should have been practised in ancient times, but that they should have been repeated at a comparatively recent period. In scrotal hernia, the testicles were often extirpated along with the hernial sac; and so common had this practice become in the seventeenth century that, as Dionis asserts, an itinerant operator was in the habit of feeding his dogs with the organs which he thus removed. Hardly less cruel and unscientific are some of the modern devices for the radical cure of this complaint, especially that of Belmas, which consists in exposing the neck of the sac, and introducing little bladders of gold-beater's skin, with a view of exciting adhesive inflammation.

Gerdy proposed invagination of the common integument. The operation is principally adapted to the inguinal form of the complaint, and simply consists, as originally executed, in pushing up a fold of skin as far as possible into the neck of the sac, which is then confined there by two points of interrupted suture, introduced by means of a stout, curved needle, through the superimposed structures—muscles, fasciæ, and skin—and separated about one-third of an inch from each other, the ends being tied over a piece of bougie. The pouch of inverted skin is then denuded of its cuticle with spirit of ammonia, which, causing inflammation in the contiguous surfaces, is thus instrumental in gluing them firmly to each other and to the peritoneum.

The operation of Gerdy has fallen into merited neglect; for, independently of the fact that it frequently completely failed, it was not always devoid of danger. Of 62 cases of it, collected by Thierry, 4 are known to have perished, while it is altogether probable that only a few were radically cured. The principles of the operation, however, have been preserved, and have, in a modified form, apparently done good service in the hands of other surgeons.

Another plan, at first sight very specious, but also found, upon trial, to be nearly useless, consists in scarifying the neck of the sac, by means of a delicate bistoury, introduced subcutaneously. Pressure is afterwards made with a truss, to approximate the opposed surfaces, in order to facilitate their union by plastic matter. This operation originated with Guérin.

Acupuncture for the radical cure of hernia was suggested, in 1836, by Bonnet, of Lyons. It is performed by transfixing the sac with a number of pins, which are permitted to remain until there is ulceration of the skin, compression being exercised in the intervals of the little instruments, for the purpose of promoting adhesive action. Of 11 cases thus treated by Bonnet, 4 were cured, 5 were unsuccessful, and 2 proved fatal; a result sufficient to condemn the procedure.

Velpeau, Pancoast, and others, have practiced a plan of treatment essentially similar to that for the radical cure of hydrocele by injection, consisting of the introduction of some mildly irritating fluid, of which tincture of iodine is, perhaps, the best. The protruded viscera having been carefully replaced, and firm pressure being made upon the hernial aperture, a drachm of iodine is thrown into the sac, and pressed about so as to bring it in contact with every portion of its inner surface. The operation is performed with a delicate trocar, with the point of which the sac is freely scarified before the fluid is forced through the canula. The injection being over, a stout compress is applied over the hernial opening, and unremittingly supported by the pressure of a well-adjusted truss. The iodine is soon absorbed, and a cure is produced by the agglutination of the contiguous surfaces. The operation, which occasionally requires to be repeated a second, and even a third time, must be performed with the greatest care, lest some of the fluid, passing into the abdominal cavity, should cause fatal peritonitis.

Dr. Jameson, of Baltimore, many years ago, performed an operation for the radical cure of a femoral hernia, upon a young lady, by dissecting up a tongue-like flap of integument, from the neighborhood of Poupart's ligament, and inserting its base, which was fully three-quarters of an inch in width, into the femoral canal. The edges of the wound were then drawn together over the flap by several sutures. For a few days the patient was restless and annoyed by vomiting; but the parts, although they did not all unite by the first intention, soon got well, the transplanted integument contracting into a hard knot over the femoral ring, which was thus completely closed, the recovery being perfect.

A very ingenious method of treatment for the radical cure of this affection was proposed by Wutzer, of Bonn, in 1838. It consists in obliterating the sac of the hernia by invaginating a portion of the integument, as originally suggested by Gerdy, by means of a peculiar instrument, composed essentially of three pieces, a wooden cylinder, a curved needle, and a wooden cover, which are retained until the contiguous structures are firmly glued together.

The wooden cylinder is three inches in length, and from three-eighths to three-quarters of an inch in diameter, according to the size of the hernial canal. It is of a somewhat flattened shape, perfectly smooth, and rounded off at the free extremity, a short distance from which, upon its inner surface, is a small opening for the passage of a long, curved needle, which is concealed in its interior, and attached to a movable handle. The cover, also made of wood, is concave on its inner surface, and of the same length and width as the cylinder, to which it is secured by a screw. It also has an opening for the passage of the needle. The accompanying cut, fig. 439, conveys a good idea of this apparently complicated, but really very simple, instrument.

The protruded parts having been returned, a fold of integument is pushed up as far as possible into the canal of the hernia with the index finger of the left hand, its palmar surface being directed forwards and upwards. The cylinder, well oiled, is then carried along the cul-de-sac thus formed, guided by the finger, which is gradu-

Fig. 439.



Wutzer's Instrument.

ally withdrawn as the instrument enters. Assuring himself that the extremity of the cylinder is fairly lodged in the internal ring, under the external oblique muscle, as he readily may by observing that it is firmly fixed in its place, the surgeon pushes the needle through the sac of the hernia, the canal, and the integument, and, screwing the cover moderately tight upon the skin, he removes the handle of the needle, leaving the remainder of the apparatus upon the abdomen. The protruding portion of the needle is protected with a piece of cork. The principal precaution necessary, in performing this operation, is to see that the cylinder is thoroughly secured in the inguinal canal. In hernia of long standing, attended with unusual laxity of the cellular tissue, it is liable to be pushed up beneath the skin of the abdomen; a circumstance, however, which is always easily detected by the fact that the instrument is more movable than when it is in its proper place.

The apparatus is retained, on an average, from six to eight days, the cover being tightened or relaxed, from time to time, according to the tolerance of the parts, and the amount of the resulting inflammation. The puncture made by the needle generally begins to suppurate about the end of the fourth day. The patient is kept perfectly at rest in the recumbent posture, pain is allayed by anodynes, the bowels are not permitted to move, and the diet is perfectly plain and simple. If peritonitis should arise, which, however, is seldom the case, the symptoms must be met by the ordinary remedies, and all compression be immediately removed. When the apparatus is taken off, the patient must not get up at once, but remain on his back eight or ten days longer; and when, at length, he rises, the parts must be carefully supported with a well-adjusted truss, steadily worn for at least six months, lest, the adhesions giving way, the disease should be reproduced.

The operation of Wutzer has been materially simplified by Professor Agnew, of this city. The apparatus required for its performance consists: first, of a steel

Fig. 440.



Agnew's Instrument for the Radical Cure of Hernia.

Fig. 441.



Curved Needle.

instrument, fig. 440, closely resembling a bivalve speculum, the blades, of which one has two longitudinal grooves, being three inches in length and connected by a hinge near the handle, which is itself controlled by a screw; secondly, of a very long, slender needle, fig. 441, mounted upon a wooden handle, and terminating in a curved point, pierced by an orifice; and, thirdly, of a common stout suture needle, two inches and a half in length.

The parts being well shaved, and a portion of scrotal integument pushed into the external ring, the instrument, with its grooved blade looking towards the abdomen, is employed to carry, by gentle but steady pressure, the invaginated plug to the upper extremity of the inguinal canal. Holding the parts in these relations, the surgeon inserts the point of a long needle, armed with a silver wire, into one of the canals of the inner blade, widely separated from the other, and, passing it on, perforates the superimposed structures. The needle, being withdrawn, is then carried along the other gutter, and thence, in like manner, across the tissues, the two punctures being about half an inch apart. In this way the base of the plug is thoroughly embraced by the loop of the wire, the ends of which are next twisted over a roll of lint upon the surface of the abdomen.

The instrument being kept steadily in its position, the sides of the inguinal canal are next approximated by three horizontal sutures, about half an inch apart, the needle, armed with a stout silk thread, being passed between the blades of the cylinder. In this way, all danger of including the spermatic cord and the peritoneum is effectually avoided.

The operation being completed, the instrument is removed, and the patient, rigidly confined to bed, is treated antiphlogistically. The horizontal sutures should not be removed for ten, twelve, or fourteen days, or until there is reason to believe that a sufficiency of plastic matter has been poured out to insure the firm union of the plug. The wire thread may, if necessary, be retained for almost an indefinite period.

Of 140 cases of hernia, operated upon, with slight modifications, according to Wutzer's method, by Professor Rothmund, of Munich, up to 1853, 117 were cured, 4 were ameliorated, 6 were not benefited, and 13 relapsed. Of the latter, some were radically cured by being operated upon a second time.

Of the amount of reliance to be placed upon these statistics, it is difficult to form a correct estimate. Rothmund himself states that many of the patients were lost sight of immediately after the operation, while, on the other hand, the cure in a great number of others was ascertained to be perfect at the end of a year and upwards. In this country, the operation of Wutzer has so signally failed that I am myself unwilling to put much faith in these assertions.

In a communication to Mr. Birkett, Dr. Otto Weber, of Bonn, states that of fourteen persons operated upon by Professor Wutzer, not one was radically cured, but that "first, the plug of skin is, by degrees, entirely drawn out again; secondly, that the true herniary apertures, the external and internal rings, are not closed by the operation; and, thirdly, that an imperfect cure may be effected by means of a partial closure, by adhesion of the internal walls of the neck of the hernial sac, and thickening of the surrounding connective tissue."

Professor Armsby, of Albany, has modified the operation of Wutzer by substituting for the needle a single thread, which is introduced, as a seton, through the hernial sac and inguinal canal, by an appropriate instrument, invagination of the integument having previously been effected, as in the other process. The thread being brought out by one end at the upper part of the internal ring, and by the other at the lower part of the scrotum, is occasionally moved, in order to provoke the requisite amount of inflammation. A truss is applied for a few hours immediately after the operation.

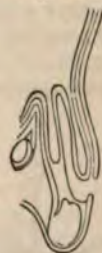
Dr. Riggs has likewise suggested the use of the seton for the radical cure of this disorder, but on a larger scale than that recommended by Dr. Armsby. In the *New York Journal of Medicine and Surgery*, for March, 1858, he described and delineated an ingenious instrument for performing the operation, and gave the results of eight cases, two from his own practice, and six from that of Professor Carnochan, nearly all being successful, without any bad symptoms having followed. Several of the cases were of very long standing.

The operation with the seton was devised by Mösner, by whom, according to Rothmund, it has been performed in 34 cases, with 29 cures, 2 ameliorations, 1 failure, 1 death, and 1 relapse.

In England, the most popular operation for the radical cure of hernia seems to be that of Professor John Wood, of London. The principle upon which it is founded consists in the approximation of the tendinous structures of the hernial canal, and in their close confinement by means of a ligature until they are thoroughly united by plastic matter and blended with the invaginated sac and the pillars of the external ring. The only instruments required are a tenotome, a semi-circular needle, mounted in a strong handle, and a silvered copper wire. The operation, as improved by its originator, is thus described by Mr. Druitt:—

"The patient being laid on his back, with the shoulders well raised and the knees bent, the pubes cleanly shaved, the rupture completely reduced, and chloroform administered, an oblique incision about an inch long is made in the skin of the scrotum over the fundus of the hernial sac. The knife is then carried flatwise under the margins of the incision, so as to separate the skin from the deeper coverings of the sac, to the extent of about an inch or rather more all around. The forefinger is then passed into the wound, and the detached fascia and fundus of the sac invaginated into the canal, as represented in fig. 442. The finger then feels for the lower border of the internal oblique muscle, lifting it forwards to the surface. By this means the outer edge of the conjoined tendon is felt to the inner side of the finger. The needle is then carried carefully up to the point of the

Fig. 442.



Invagination of the Sac.

finger along its inner side, and made to transfix the conjoined tendon, and also the inner pillar of the ring. When the point is seen to raise the skin, the latter is drawn over towards the median line, and the needle made to pierce it as far outward as possible. A small hook bent on the end of the wire is now attached to the eye of the needle, drawn back with it into the scrotum, and then detached. The finger is next placed behind the outer pillar of the ring, and made to raise that and Poupart's ligament as much as possible from the deeper structures. The needle is then passed along the outer side of the finger, and pushed through Poupart's ligament a little below the deep hernial opening. The point is then directed through the same skin puncture before made, the other end of the wire hooked on to it, drawn back into the scrotal puncture as before, and then detached. Next, the sac at the scrotal incision is pinched up between the finger and thumb, and the cord slipped back from it, as in taking up varicose veins. The needle is then passed across behind the sac, entering and emerging at the opposite ends of the scrotal incision, as delineated in fig. 443. The end of the inner wire is again hooked on, and drawn back across the sac.

Fig. 443.



Passage of the Needle behind the Sac.

Fig. 444.

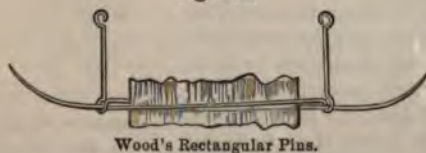


Operation as Completed.

"Both ends of the wire are then drawn down until the loop is near the surface of the groin above; and are twisted together down into the incision, and cut off to a convenient length. Traction is then made upon the loop. This invaginates the sac and scrotal fascia well up into the hernial canal. The loop of wire is firmly twisted close down into the upper puncture, and bent down to be joined to the two ends in a bow or arch, under which is placed a stout pad of lint, as in fig. 444. The whole is held steady by a spica bandage." The wire is allowed to remain from ten to fourteen days, or until it becomes loosened by ulceration, when it is untwisted and withdrawn upwards.

"For small herniæ and the herniæ of children," says Druitt, "Professor Wood employs a pair of rectangular pins, one of which is made to traverse, from above downwards, the conjoined tendon and inner pillar, and the other Poupart's ligament from below upwards. Both these pins are made to enter and emerge at the same cutaneous aperture, without any incision of the skin. During their application the forefinger invaginates the thin skin of the scrotum into the hernial canal, and thus protects the important deep-seated parts. The same structures are transfixed as described in the preceding operation. The pins are bent at a right angle near the blunt end, and provided with loops at the bent part, fig. 445, so that each can be locked in the loop of the other, and then by a half-turn can be twisted

Fig. 445.



Wood's Rectangular Pins.

around so as to entwine closely the included structures, and cause them to adhere intimately, as the pins ulcerate nearer to each other and finally meet."

Up to 1870 Professor Wood had employed the above operations and his earlier method with a hempen thread in 155 cases, of which 133, so far as could be ascertained, were satisfactory cures, while only two proved fatal. Of 22 completed cases from the practice of Dr. Cheever and of the Boston City Hospital, 3 were permanently cured, 3 were much relieved, 2 died, and 14 failed.

The cases best fitted for these various procedures are such as are of comparatively recent standing, and unaccompanied by any great bulk of the tumor. When the canal is much diminished in length, and increased in diameter, as generally occurs in old ruptures, in which the orifices of the canal are on the same line, and immediately above each other, a cure will generally be impracticable by any method whatever. To femoral, umbilical, and ventral hernias, these procedures are not adapted, owing to the great risk of peritonitis and extensive suppuration.

The most rational radical treatment of hernia is undoubtedly the *direct*, as it may be termed, consisting in cutting down upon the parts, refreshing the edges of the opening of descent, and approximating them with wire sutures, either permanently retained, or until complete consolidation has been effected. The operation, it will be perceived, is founded upon the same principle as that for harelip and cleft palate, and will, if properly executed, be much more likely to answer the purpose than the process of invagination, now so much in vogue, and, for the most part, so worthless. The proceeding is easy of execution, and does not, if the system has been properly prepared by rest, abstinence and other means, involve any particular danger. It is, of course, not so applicable to ruptures with large openings as to those of an opposite character, as it would be difficult in such an event to effect accurate contact. No interference with the proper hernial sac is necessary. The parts, after the patient gets up, should be for a long time supported with a truss.

I have performed this operation only twice. In the first case in which the hernia was consequent upon a wound of the abdomen, in a young man, about thirty years of age, I succeeded in effecting a very excellent cure by cutting down upon the parts, and closing the opening with four interrupted silver sutures, carried through its muscular edges, previously well pared, as in harelip. The operation, performed in December, 1858, at the clinic of the Jefferson Medical College, was unattended by a solitary unpleasant symptom. In a case of large, old scrotal hernia, in a man sixty-two years of age, upon whom I operated in 1861, in a similar manner, at the Philadelphia Hospital, the cure was equally perfect, although the parts had been seized with an alarming attack of erysipelas.

Spontaneous Cure.—A hernia occasionally gets well spontaneously. Such an event is, of course, most likely to occur in very young subjects, in whom the opening in the walls of the abdomen, whether natural or artificial, is very small. I recollect an instance, however, in which a very rapid cure took place, where the aperture was of immense size. The patient, an infant, three weeks of age, had a tumor in the right groin, fully equal to the volume of an ordinary adult fist. The parts being replaced, the abdomen was supported with a compress and a broad flannel bandage, after which no further protrusion occurred. I have met with several cases in which ruptures of considerable size were permanently cured during severe illness, necessitating long confinement in the recumbent posture. The flaccid condition of the bowels attendant upon such cases leaves the walls of the abdomen comparatively free from pressure, and thus places the hernial apertures in a situation highly favorable to contraction and ultimate obliteration. In umbilical rupture a spontaneous cure is by no means uncommon, owing to the natural disposition of the ring to close.

Sometimes a radical cure is effected by the interception of a portion of omentum in the opening of descent. I have witnessed this occurrence both in scrotal and femoral hernia, and there is no doubt that it may also happen in the inguinal and umbilical varieties of the complaint. The plug which is thus formed contracts permanent adhesions to the opening, so as effectually to prevent any further protrusion. Some years ago a young man consulted a surgeon on account of a small tumor in the right groin, a short distance below Poupart's ligament; it was free from pain, about the size of an ordinary marble, and of several years' standing. Under a belief that it might grow, and ultimately cause trouble, it was removed. A careful dissection showed that it was nothing but a mass of omentum, firmly adherent to the edges of the orifice of an old rupture. The operation was speedily followed by a redescend of the viscera.

2. IRREDUCIBLE HERNIA.

An irreducible hernia is one in which the protruded parts do not admit of replacement. Various causes may conspire to produce such a result. Some of these causes are altogether of an adventitious character; others relate to changes experienced by the prolapsed structures, in consequence of their long sojourn on the outside of the peritoneal cavity; and others, again, depend upon the condition of the edges of the opening, whether normal or abnormal, at which the hernia has occurred. Finally, the difficulty may exist in the peritoneal cavity. These causes are of great practical importance, and, therefore, demand separate consideration.

Under the first head of causes, here designated as the adventitious, may be enumerated the adhesions which are so liable to form between the hernial sac and its contents. These adhesions, which are always the direct result of inflammation, are of variable firmness and extent, according to their duration and the amount of plastic effusion. Sometimes all the protruded structures are united, not only to each other, but to the walls of the sac, although, in general, certain portions are free, while the remainder are more or less adherent. Occasionally distinct bands are seen stretching from one coil of intestine to another, or from a portion of bowel to a portion of omentum, or, finally, from the prolapsed parts to the surface of the hernial sac. In ancient cases the plastic matter often presents itself in the form of cellular tissue, as, under corresponding circumstances, in the pleura and peritoneum.

Secondly, a hernia may be rendered irreducible by the alterations experienced by the protruded structures themselves from interstitial deposits. The omentum is remarkably prone to hypertrophy from protracted residence on the outside of the abdomen, and similar changes, although not in an equal degree, are liable to occur in the bowels. The parts being thus enlarged, perhaps several times beyond their normal volume, are finally rendered incapable of being restored to their original situation. Another cause of the irreducibility of a rupture, but one usually of a more transient character, is the impaction of the bowel with fecal matter, gas, worms, alvine concretions, or some indigestible substance. Sometimes, again, a hernia, originally reducible, may be rendered irreducible by the manner in which the prolapsed parts, especially if consisting of intestine and omentum, are twisted around each other.

Thirdly, the cause of the difficulty may exist in the opening in the wall of the abdomen, the margins of which may either contract, and thus prevent the return of the protruded parts; or the orifice may retain its original dimensions, and yet, in consequence of the changes experienced by the contents of the tumor, the hernia may be rendered irreducible. The whole difficulty, in either case, is evidently due to a loss in the relative size of the parts concerned in the disease.

Finally, the irreducibility of the hernia may depend upon the contraction of the peritoneal cavity, or an unwillingness, so to speak, on the part of this cavity, to reclaim its original possessions. Such an occurrence is very likely to happen in very large and old ruptures, embracing an unusual quantity of bowel and omentum, or of bowel and some solid viscus, as the liver, spleen, or uterus. The parts, having resided for a long time in their new situation, are found, when an attempt is made to restore them to their former position, to be too bulky for the now contracted size of the abdominal cavity.

The above causes, excepting the first, are generally tardy in their operation, and, therefore, a considerable period often elapses before the protruded structures become finally irreducible. When inflammation is set up in the sac, or in the prolapsed parts, whether accidentally or otherwise, a hernia may be rendered irreducible in a very few days. The varieties of rupture most liable to this occurrence are the scrotal and umbilical.

Persons affected with irreducible hernia are subject to habitual derangement of the digestive apparatus, especially flatulence, eructations, acidity, nausea, colicky pains, and constipation of the bowels. The size of the tumor varies; it often remains stationary, or nearly so, for years, but in the end it is sure to increase, and frequently attains an enormous bulk.

When a hernia has been long irreducible, it may, especially if unusually bulky, or improperly treated, cause serious irritation both in the sac and in the neighboring parts. Such an effect will be more likely to follow, other things being equal, when the contents of the rupture are composed of omentum than when they consist of

intestine, owing to the fact that the former, gradually yielding to the pressure so incessantly exerted upon it, is apt to become not only greatly hypertrophied, but completely metamorphosed in its structure, thus unfitting it for safe companionship. More than one instance has been known where such a state of things has caused death by ascites or suppuration, the inflammation extending from the sac and the protruded omentum to the peritoneum or to the omentum within the abdomen.

Treatment.—In the treatment of irreducible hernia, three prominent indications are presented: first, to render the affection, if possible, reducible; secondly, where this cannot be done, to prevent its increase; and, thirdly, to palliate the suffering caused by the confined and compressed condition of the displaced parts.

The probability of a successful fulfilment of the first indication will depend materially upon the circumstances of each individual case, and cannot, therefore, be stated with any degree of precision. The most important of these circumstances are, the size and age of the hernia, and the condition of the general health. A small tumor will, other things being equal, be more likely to become reducible than a large one, and one of recent standing than one that is old. Indeed, it is questionable, when the tumor is very bulky, whether its contents ought to be returned, supposing that they could be disengaged, on account of the injurious impression which they would create in the abdominal cavity, which, in consequence of their long absence and great size, would be little disposed to accommodate itself to their presence, or provide for them a new home. The chances of a fortunate issue will also be greater in a sound than in a sickly person, the function of absorption, upon the vigorous execution of which the favorable result essentially depends, being always performed more energetically in the former than in the latter. The measures best calculated for fulfilling this indication, whether the cause of the non-reducibility be hypertrophy or adhesion, are, rest, recumbency, low diet, venesection, purgatives, mercurials, and sorbefacient applications.

Without repose in the recumbent posture, absolute, steady, and protracted, no course of treatment, however judiciously conducted in other respects, will be likely to prove of the slightest avail. The diet should be non-stimulant, farinaceous, and barely sufficient to support life; it should be low, in the broadest sense of the term. If the patient is young and robust, the treatment may be commenced with the abstraction of sixteen to twenty ounces of blood, to be repeated afterwards to one-half, one-third, or one-fourth of that extent every eight, twelve, or fifteen days, until the patient is so far drained of fluids as absolutely to forbid any further depletion. In old and enfeebled subjects, the lancet must either be withheld entirely, or used with much caution. Purgatives will be of the greatest benefit throughout the whole course of the treatment, whether short or protracted, or whatever may be the condition of the patient in other respects. They not only unload the bowels, and thus prevent fecal accumulation in the protruded viscus, but they aid in equalizing the circulation, and in promoting absorption. The best articles are compound extract of colocynth, jalap, and blue mass, in doses sufficiently large to produce one or two efficient motions, and repeated every third, fourth, or fifth night. Their action may, if necessary, be assisted by enemata or saline laxatives.

As soon as the system has been properly prepared by diet, venesection, and purgatives, the patient should be subjected to the use of mercurials, such as calomel, blue mass, or corrosive sublimate, with a view to gradual ptyalism, which should be steadily, but cautiously, continued for many weeks. Such a course is always equally indicated, whether the cause of the irreducibility of the hernia be hypertrophy or adhesion of the protruded viscera. The manner in which it proves beneficial need not be pointed out here, as it has been explained elsewhere. Along with the mercurials might be used, more or less freely, the iodide of potassium, and hydrochlorate of ammonia, alternately every other week, in doses varying from eight to fifteen grains thrice a day.

As it respects the local treatment, the first thing to be done is to suspend the tumor by means of an appropriate apparatus, so that it may receive no injurious impulse from coughing, straining, or other muscular exertion. Sorbefacient lotions, as solutions of acetate of lead, Goulard's extract, or, what is better, hydrochlorate of ammonia, are then diligently applied. Various stimulating liniments and unguents may also be used, especially after the case has been for some time under treatment. Occasionally steady, systematic compression answers a good purpose; maintained either with adhesive strips, as in the treatment of subacute orchitis, or by means of

a truss with a hollow pad, lined with layers of leather, or furnished with a gum-elastic air cushion.

It is impossible to affirm how long, in any given case, this mode of treatment should be continued, before its good effects will become apparent, or the probability of its inutility can be determined. In the few cases in which I have employed it, it was extremely difficult to secure the hearty coöperation of the patient beyond six or eight weeks. This procedure, it will be perceived, is essentially similar to that of Valsalva for the radical cure of aneurism, and was, doubtless, originally suggested by the circumstance that, during protracted illness, an irreducible hernia has occasionally disappeared spontaneously, the protruded viscera having become disengaged from their sac, or having drawn the sac along with them into the abdominal cavity.

When the case is hopelessly irreducible, all that can be done is to support the parts properly to prevent their further descent, and, at the same time, protect them from injury. When the tumor is small, the best contrivance is an ordinary spring truss with a hollow pad, made either of metal, gutta-percha, or unoled sole-leather, its interior being well padded with buckskin, or some other soft, pliant material, to protect the surface from undue pressure. Such an apparatus will answer nearly equally well for all varieties of irreducible hernia, whether inguinal, femoral, umbilical, or ventral. When, on the contrary, the tumor is very bulky, the gum-elastic suspensory takes the place of the hollow truss, as better adapted to sustain the heavy and pendulous mass. As now manufactured, it is difficult to imagine anything of the kind more perfect, comfortable, and convenient. It is incomparably superior to the numerous and clumsy contrivances formerly so much in vogue. The suspensory, while it may be readily adapted to all the varieties of irreducible rupture, is particularly applicable to the scrotal, the descent of which it is well calculated to restrain by the steady and uniform compression which it exercises upon the pendulous tumor.

The colicky pains, dragging sensations, and dyspeptic symptoms, so common in persons laboring under irreducible hernia, are best relieved by attention to the diet and bowels, and the avoidance of severe muscular exertion. The food should be plain, simple, and concentrated, comprising the greatest possible amount of nutriment in the smallest possible space; acidity and flatulence should be remedied by alkalies, especially the bicarbonates, carminatives, and tonics; and the bowels should be maintained in a soluble state by some mild vegetable pill, citrate of magnesia, or saline cathartic. In short, the patient, while he should consider himself constantly as an invalid, should do everything in his power to keep his health as near as possible at the normal standard; neither starving himself, on the one hand, nor indulging in any excesses, on the other.

Inflamed Irreducible Hernia.—An irreducible hernia, particularly if it be one of large size, may occasionally be assailed by inflammation, brought about either by external violence, or by the inordinate accumulation of irritating fecal matter in the incarcerated intestine. The symptoms denotive of the occurrence are generally those of an ordinary circumscribed peritonitis; hence, unless the case is carefully investigated, it might very readily be mistaken for one of strangulation. The attack is usually announced by pain and tenderness in the parts, attended with a sense of weight and tension, but without any marked increase in the size of the tumor. The skin soon becomes hot, if not also discolored, and there is occasionally a good deal of œdema. The constitutional involvement is seldom considerable, unless, as sometimes happens, there is a tendency to the formation of a stercoraceous abscess, when it will, of course, be proportionately severe. Vomiting now and then takes place, more especially in the earlier stages of the attack, generally as a consequence of the presence of irritating ingesta, as if nature were desirous of relieving herself in this way, but the matter ejected is never feculent, and this fact, coupled with the circumstance that the patient, although laboring under constipation, is still able to pass flatus and fluid feces, is usually sufficient to distinguish the complaint from strangulation. Moreover, in inflamed hernia, the ring is generally free from tension, and the pain is always referred, in the first instance, to the body of the tumor, whereas, in strangulation, it is originally most severe at the site of stricture.

The treatment is conducted upon general antiphlogistic principles; by rest and elevation of the parts, the application of leeches; anodyne and saturnine lotions, laxative injections, and strict abstinence. Purgative medicine is carefully avoided,

and it may even be necessary to control the action of the bowels with opiates, in the same manner as in ordinary peritonitis.

Obstructed Irreducible Hernia.—Another source of trouble in irreducible hernia is obstruction from the accumulation and impaction of fecal matter and flatus. The occurrence is most common in large ruptures of old subjects, and may exist independently of inflammation and strangulation, although both may ultimately supervene, especially if the parts be subjected to rough manipulation in the employment of the taxis. The immediate cause of the obstruction is usually some adhesion between the protruded structures and the sac, leading to the formation of an elbow or angle in the incarcerated bowel at variance with the propulsion of its contents, or, what is the same thing, their return into the abdomen. The most prominent symptoms are colicky pains, flatulence, constipation, and irritability of the stomach, with occasional vomiting of ingesta, or ingesta, bile, and mucus. The tumor is generally free, at least for a considerable length of time, from pain and tension, although it may be somewhat tender on pressure.

The treatment may be commenced with a stimulating enema, as a mixture of turpentine and castor oil, to clear out the lower bowel. The fluid should be introduced with the gum-elastic tube. When this object has been attained, recourse may be had to the taxis, in the hope of being able to empty the obstructed intestine of feces and flatus, the patient being at the time under the influence of chloroform. If the success attending the operation is only partial, a brisk purgative may next be administered, and if this also should fail, the knife must be used. When the difficulty depends mainly upon the presence of flatus, it may usually be speedily overcome by puncturing the bowel with a small trocar, the gas readily escaping along the canula of the instrument.

3. STRANGULATED HERNIA.

Strangulated hernia is that form of the disease in which the protruded parts are firmly, painfully, and injuriously compressed by the edges of the opening at which the descent has taken place, or at the neck of the sac, as seen in fig. 446. Sometimes, however, the constriction occurs at the mouth of the sac, in the interior of the sac, or between the prolapsed structures themselves. Thus, a protruded bowel has occasionally been strangulated by being tightly wrapped up in a piece of omentum, or by being forced through a fissure in the substance of the omentum. In enterocele, the constriction is usually caused, not by the constriction of the ring, but by the increased size of the bowel from the presence of gas and fecal matter, interfering with its return to the abdominal cavity. In entero-epiplocele, only one of the protruded structures is sometimes strangulated, the other perhaps escaping constriction entirely. Such an event is, of course, most likely to occur in large and old ventral ruptures.

It is not often that a recent rupture is exposed to the danger of strangulation; in general, it is only when the parts have been seriously changed by interstitial deposits, or, in other words, when the hernial canal and rings have become greatly contracted or the protruded structures have disproportionately increased in bulk, that such an event is likely to occur. Of 100 cases of this disease, analyzed by Mr. Wilkinson King, of London, the mean duration of the rupture in 61, prior to the supervention of strangulation, was about twenty years; whilst out of 98 cases, 94 were in various degrees "old" before this occurrence.

Recent ruptures, however, especially if small, are, other things being equal, remarkably prone to be attended with violent suffering when strangulation occurs. In such an event, too, the danger both to the part and system is always much greater when the strangulation is not promptly relieved than in hernias of large size and of long standing, for the reason that the constriction is usually more severe in the former than in the latter, and, therefore, more liable to be followed by mortification. The varieties of hernia in which the strangulation is commonly most violent and

Fig. 446.



Strangulated Hernia.

hazardous are the femoral and concealed inguinal; both usually of small size, and for this reason, unfortunately, apt to be overlooked. Sometimes, indeed, the stricture includes only a very small portion of the bowel, not enough, perhaps, to form the slightest appreciable external tumor.

Strangulation commonly takes place suddenly, from violent muscular exertion, as in leaping, running, lifting, or coughing. However induced, the person is soon rendered conscious of the occurrence by the tender state of the tumor, and by a sense of general uneasiness in the abdomen. Gradually, perhaps rapidly, the suffering increases; the parts become exquisitely painful, both at the site of the swelling, and for some distance around; the slightest touch, even of the finger, is frequently intolerable; a feeling of constriction, as if a cord were stretched tightly around the belly, is often complained of; the patient lies upon his back, with the knees retracted and the shoulders elevated, in order to relieve the parts as much as possible of tension; there is more or less restlessness, and even jactitation; the pulse is frequent, hard, and wiry; the mouth is dry, the thirst urgent, the surface hot, the countenance flushed, and the head oppressed with pain. By and by nausea and vomiting occur, at first of ingesta, then, perhaps, of bile and mucus, and finally of stercoraceous matter; hiccup now sets in, and twitching of the tendons soon becomes a prominent symptom. The mind wanders, sometimes even at an early stage, and not unfrequently there is low, muttering delirium. The bowels are usually obstinately constipated from the first, or, if there be any alvine discharge, it is derived entirely from the part of the bowel below the seat of the mischief. If, when the case has reached this crisis, prompt relief be not afforded, another series of changes occurs, still more striking and portentous. The countenance now assumes that peculiar shrunken aspect, so well described by Hippocrates, and hence usually called by his name; the tongue is dry, tremulous, and unable to protrude itself; the gums and teeth are incrustated with sordes; the surface is covered with clammy perspiration; the extremities are icy cold; the tumor, of a livid color, crackles under pressure; and the patient is in a state of the utmost exhaustion, incapable, it may be, of answering any questions, or of maintaining himself upon his pillow. The pain, previously complained of, has suddenly ceased, and the poor sufferer, if not wholly unconscious of his condition, perhaps flatters himself that he will soon be well, when, in fact, he is in the very jaws of death. Mortification of the protruded parts has taken place, and his only hope of safety is in the formation of an artificial anus. The period at which death occurs varies, on an average, from three to five days, being generally earlier in strangulation of small and recent hernias than in large and old.

The symptoms of strangulation, especially in its earlier stages, are not always as urgent as they are here represented. Sometimes, indeed, they are exceedingly mild, even for several days, when, perhaps all of a sudden, they become greatly aggravated, and denotive of the worst consequences. It is worthy of remark, too, that they are usually more severe in strangulation of the bowel than in strangulation of the omentum, although the difference is not so great as is commonly supposed.

The *diagnosis* of strangulated hernia is usually readily determined by the history of the case, a thorough examination of the abdomen, especially of those regions which are most liable to visceral protrusion, and a careful consideration of the constitutional and local phenomena. There is always a partial, and, when the stricture is very tight, a complete, interruption between the sac and the general peritoneal cavity; and hence, if the patient cough, while the fingers are pressed upon the tumor, no impulse will be imparted to them. Moreover, if the tumor be grasped firmly with one hand, and alternately squeezed and relaxed, while the index finger of the other hand is placed upon the neck of the hernia, opposite the seat of the stricture, the impulse produced by the compression will cease abruptly at the seat of the obstruction, owing to the fact that the contents of the sac cannot be forced farther on, as happens when the communication remains free. The chief difficulty in regard to the diagnosis of strangulated hernia arises from the circumstance that there is occasionally no external tumor whatever, or, if a tumor be present, that it is impossible to determine whether it is a hernia, an incipient abscess, or an inflamed lymphatic gland. Besides, it should not be forgotten, as will be shown by and by, that all the symptoms of strangulated rupture are sometimes most painfully simulated by various internal affections, as intussusception of the bowel, or strangulation of the bowel and omentum by bands of false membrane. The mere mention

of these facts should be sufficient to impress upon the mind of the surgeon the importance of increased vigilance in his examinations of all doubtful cases of this kind, as everything may depend upon a correct diagnosis.

The attention of the surgeon should be particularly aroused if the patient is suddenly seized with obstinate vomiting, attended with constipation, and speedily followed by excessive prostration, pain in the bowels, tenderness of the abdomen, and a pinched and anxious expression of the countenance. Such symptoms should always excite a suspicion of the existence of a hernia, and, therefore, no time should be lost in exploring every region of the body in which this affection is liable to show itself. The inguinal and femoral rings, the umbilicus, and the linea alba, in particular, should always be most carefully scrutinized, as they are the most common sites of rupture. If the local distress is very circumscribed, and there is a tumor, small, tense, and very tender, the probability is that the disease is a hernia, and nothing else.

Sometimes a tumor and a hernia coexist. Such an occurrence is most liable to take place in the groin, from enlargement of a lymphatic gland. Thus, great embarrassment may arise, the surgeon, perhaps, finding it very difficult what to do; but the invariable rule in such a case is to operate, no particular harm accruing if the enlargement is a common tumor, whereas if it be a strangulated rupture, the patient might perish from neglect of proper treatment.

Doubt in regard to diagnosis may arise when a man, long the subject of hernia, is affected with vomiting and spasm of the bowel, attended with constipation, and is found, upon examination, to have a tumor in the abdomen, the hernia itself being perfectly reduced. Here the enlargement will probably be due to circumscribed fecal distension of the intestine, upon relieving which the symptoms will subside; or it may be caused by disease of the omentum, spleen, liver, or ovary, in general easily distinguishable from rupture.

The symptoms of intestinal strangulation may be closely simulated by colic, enteritis, or peritonitis supervening upon an irreducible hernia. When the pain begins in the neck of the sac, and is particularly intense there, the probability is that it is due to strangulation; whereas, if it be widely diffused, it may be inferred that it is owing to some other affection. In doubtful cases the rule is to operate.

Finally, a man may have a double hernia, and, symptoms of strangulation arising, doubt may ensue as to the precise seat of the disease. Under such circumstances the rule is to operate first upon the tumor that is the more tense, tender, and painful, and afterwards, if necessary, upon the other.

Dissection of the body after death from hernia generally reveals nothing but the ordinary evidences of peritonitis. The protruded parts are in a state of the most profound vascular engorgement, livid, purple, or claret in color, and incrustated with plastic matter, as in fig. 447. If gangrenous spots exist, they are easily recognized by their greenish or blackish hue, and by their soft consistence. At the seat of the stricture the bowel is usually ulcerated, or pierced with apertures, commonly so small as hardly to admit even of the escape of gas, much less of mucus and feces. Occasionally the only morbid change there is a ring-like groove in the walls of the intestine. The sac, participating in the morbid action, generally exhibits strong traces of inflammation. On laying it open there is almost always an escape of serous fluid, varying much in quantity and color in different cases, and under different circumstances. While it is seldom entirely absent, in any instance, it rarely exceeds half an ounce or six drachms, the average ranging from one and a half to two drachms. Its color, at first, is like that of water, but, as the strangulation advances, it is rendered red, dark, or purple, from the admixture of hematin. Occasionally, although rarely, the sac contains pure blood, or a fluid resembling coffee grounds in color and consistence. Such occurrences are most liable to happen in cases in which the stricture has been more than usually tight, or the effort at reduc-

Fig. 447.



Strangulated Bowel. *aa*. The Constricted Portion; *b*. The Cardiac Portion, Dilated, and of Dark Color; *c*. The Lower Portion, nearly Empty, Flaccid, and Pale.

tion uncommonly severe. The external investments of the tumor are more or less congested, discolored, and, when the mortification has extended also to them, emphysematous, from the extrication of gas.

The protruded and strangulated bowel, especially in cases of old ruptures, sometimes contains foreign bodies, as fish and chicken bones, pins, pieces of cartilage, applecores, and other undigested substances, which may thus not only add greatly to the irritation of the parts but also to the difficulty of the reduction.

The general peritoneal surface also exhibits traces of the effects of the strangulation, being always most distinct at and immediately around the seat of the constriction. The affected parts are variously discolored, incrustated with lymph, and here and there adherent. Not unfrequently the cavity of the serous membrane contains a small quantity of altered fluid.

If the patient survives the effects of the mortification, the superincumbent structures of the hernia slough away, and, the dislocated bowel being also opened, an artificial anus is established, admitting thus of the discharge of fecal matter along the upper portion of the tube; while that which intervenes between the accidental and natural outlets, gradually unburdening itself of its contents, sinks into a state of collapse.

Treatment.—For the relief of strangulation, various means are at our command, all resolving themselves into the one great and important element of an early and effectual reduction; for it must be evident that there can be no safety, either for the parts or the patient, so long as the protruded viscera are permitted to remain in their constricted condition. The sooner, therefore, an attempt is made to restore them to their natural situation, the greater will be the chance of preventing inflammation, so much to be dreaded in all cases of this kind, because it constitutes the chief source of danger. The period at which inflammation supervenes after the occurrence of strangulation varies from a few hours to several days, depending mainly upon the nature of the protrusion, the character of the stricture, and the state of the system. As a general rule, it may be assumed that the occurrence will be early in direct ratio to the small size and recent standing of the hernia, the firmness of the parts opposing restoration, and the robustness of the patient. Once begun, the inflammation may proceed with great rapidity, involving not only the whole of the protruded viscera, but extending, on the one hand, to the general peritoneal cavity, and, on the other, to the various coverings of the tumor. Hence, no one can doubt the propriety of early restorative interference.

The rapidity with which death occasionally occurs from strangulation of the bowel in hernia would almost challenge belief, if the fact were not well attested. Sir Astley Cooper mentions an instance in which a person lost his life in eight hours from the commencement of the attack; and a still more extraordinary case has been recorded by Baron Larrey. Death, under such circumstances, is evidently due to shock, and not to the effects of the inflammation, and will be most likely to occur in a small, recent hernia.

The means that are employed for effecting the reduction of the strangulated parts constitute what is called the *taxis*, a Greek term, signifying to set it in order, or to restore what has been deranged. It has reference merely to certain manual efforts at replacement, which should always be tried before we resort to the knife. The only exception to this rule is where the strangulation has existed so long, and the symptoms, local and constitutional, are so urgent, as to render it probable that, if practised, the protruded structures would suffer serious detriment. In such a case, the best *taxis* is the knife.

In order to impart thorough efficiency to the *taxis*, it is necessary, first to evacuate the bladder, and also the rectum, provided it is much distended; secondly, to relax the abdominal muscles; and, thirdly, to use certain adjuvants, as chloroform, venesection, and external applications. The first of these objects is attained by the patient's own efforts, or, if necessary, by the catheter, and by a slightly stimulating enema; and the second, by placing the patient upon his back, and elevating the head and shoulders, the thighs being bent nearly at a right angle with the trunk, and held close together by an assistant, with the toes somewhat inverted. In most cases, if, indeed, not in all, great advantage will be derived from putting a pillow under the buttocks, so as to lift up the pelvis. In this manner, the points of attachment of the abdominal muscles being made to approximate each other, the greatest possible degree of relaxation will be secured; a circumstance of primary importance in

all such proceedings. The third indication is fulfilled by the administration of chloroform, carried to the extent of complete obliviousness. The part and system being thus thoroughly relaxed, the surgeon, standing, sitting, or kneeling, as may be most convenient, at the right side of the patient, as he lies upon the edge of the bed, the sofa, or the floor, grasps the tumor with the right hand, and draws it carefully downwards towards himself, to disengage the protruded parts from the neck of the sac, and at the same time give them the proper direction in relation to the outlet of the opening or canal through which they descended. This being done, he exerts gentle, uniform, and steady pressure upon it, to force out its contents, the left thumb and index finger being applied to the upper part of the tumor for the purpose of fixing it at that point, and thus promoting the reduction. If the hernia is very large, the manipulation is performed with both hands, with a degree of caution the greater as the force will now be likely to be more considerable. In a few minutes—perhaps only a few seconds—after the pressure has been applied, the operator will generally be conscious of a slight noise, as well as of a slight diminution of the tumor, caused by an escape of gas, and, perhaps, also of fecal matter. Steadily continuing his efforts, he finds that one portion after another of the protruded parts goes up, the last usually with a distinct gurgling sound, until the sac is completely emptied. Sometimes the most trifling pressure is sufficient for the replacement, while at other times a large amount is necessary. When the hernia consists both of bowel and omentum, the former generally ascends before the latter, although in this respect there is not a little diversity in different cases.

The length of time during which the taxis should be continued must vary according to circumstances; in general, an old hernia will, when strangulated, bear pressure much better, and also for a longer time, than a recent one, and a large than a small one. Much will likewise depend upon the amount of inflammation that may be present in the protruded viscera, the parts being always most tolerant of manipulation when this is slight, or when it exists only in a moderate degree. Then, again, a good deal will depend upon the peculiarity of each individual, one person enduring pain much better than another, although the bowel and omentum may be equally severely compressed in both. When the symptoms are urgent, it is a good rule not to continue the efforts at the taxis beyond ten, twelve, or, at most, fifteen minutes, but to proceed at once to an operation, or, what is preferable, to administer a full anodyne, and cover the tumor with some refrigerant lotion. At the end of some hours, the manipulations may be renewed, and now, perhaps, with a better prospect of success, seeing that the parts have had time to become soothed and relaxed. These attempts, however, also failing, the operation should be commenced without delay.

The taxis may be aided, in addition to chloroform, by venesection, the warm bath, anodynes, and various external applications.

Venesection, to the extent of partial syncope, has generally been viewed as one of the most valuable auxiliaries of the taxis. The blood should be drawn in a full stream, while the patient is in the erect or semierect posture, the object of the operation not being spoliative, but exhaustive. Thus performed, it seldom fails to relax the abdominal muscles, to reduce the tumor, and to prevent or relieve inflammation. Bleeding, however, is not to be resorted to indiscriminately; for, while it is exceedingly important in small and recent hernias, occurring in young, robust subjects, with a strong, hard, and frequent pulse, and great tenderness of the abdomen, it is altogether inadmissible in protracted strangulation, or in aged and debilitated persons. A small, rapid, and wiry pulse, so characteristic of peritonitis, does not contraindicate the propriety of venesection, unless there be other evidence of prostration, as coldness of the extremities, profuse perspiration, and collapse of the features. In my own practice, a resort to bleeding, as an auxiliary of the taxis, has been exceedingly uncommon, chloroform having afforded me all the aid that could be desired. When the parts are much inflamed, blood may sometimes be advantageously taken from the tumor by leeches.

The warm *bath* is used nearly with the same view as venesection, to depress the system, and induce relaxation of the abdominal muscles. The temperature, at the moment of the immersion, should be about 96° of Fahrenheit, from which it should be gradually raised to 110°. As soon as a disposition to faintness is felt, the taxis is renewed, and is then often successful, especially if aided by anesthesia. Owing to the inconveniences attending its use, the warm bath is rarely employed in private

practice, and perhaps this is well, for there is certainly not much sense in parboiling a man when he can be so easily relieved with the aid of chloroform.

Among the adjuvants of the taxis, *anodynes* hold deservedly a high rank. They sometimes succeed when everything else fails. They relieve vomiting, diminish the morbid sensibility of the tumor, tranquillize the system and induce sleep, during which the reduction of the hernia is occasionally effected as if by magic. They should be given in full doses, either in the form of morphia, opium, or laudanum, according to the judgment of the practitioner. When they cannot be taken by the mouth, they should be administered by the rectum, which, indeed, is sometimes the preferable mode. In this way, I have repeatedly succeeded in effecting the reduction of a strangulated hernia, with the greatest facility. A good rule, when the symptoms are urgent, is to administer from a third to half a grain of morphia hypodermically, and, if the parts do not return of their own accord during the resulting sleep, to employ the taxis within from three to four hours afterwards, or before the effects of the medicine have begun to pass off. It has happened, more than once, that a strangulated hernia, upon which the taxis had been tried in vain, has spontaneously disappeared during a natural sleep, much to the annoyance of the ever-ready knife's-man.

No educated surgeon of the present day thinks of employing *tobacco* and tartar emetic, as auxiliaries of the taxis. Fortunately this practice, which numbers many victims, has become obsolete. Prior to the discovery of chloroform, as an anæsthetic agent, there was some excuse for the use of these potent remedies; certainly none exists at the present day.

The employment of *purgatives*, too, cannot be too pointedly condemned, inasmuch as they are liable to cause vomiting and griping, and, by propelling the contents of the bowel against the strangulated portion of the tube, distention and inflammation of the canal above the seat of the stricture. In omental rupture they cannot exert the slightest agency in extricating the protruded mass. Some benefit may be expected, especially in large and old hernias, from stimulating injections, as castor oil and turpentine, or senna and salts, used copiously by means of a gum-elastic tube carried high up the rectum. The peristaltic action thereby induced unloads the large intestine, and occasionally draws the strangulated portion of the canal into the abdominal cavity. I have in several instances seen a similar effect produced by a large enema of ice-water.

Applications made directly to the tumor and the parts immediately around are sometimes beneficial, both in effecting relaxation and relieving inflammation. With this view two classes of remedies, very opposite in their character, may be used, namely cold and warm. Respecting their relative merits, it is impossible, in the existing state of the science, to form any accurate opinion. It is certain, however, that they are not both equally applicable in all cases or in all circumstances. The best plan, undoubtedly, is to be governed, at least in some degree, in their employment, by the feelings of the patient, or the tolerance of the part and system. As a general rule, it will be found that cold applications will be borne best by the young and robust, and in cases of recent standing, whereas warm will be most agreeable when the patient is delicate and nervous, or old and feeble.

I have myself always derived most advantage from cold, applied over a layer of soft, wet flannel, by means of a small bladder partially filled with pounded ice, or a refrigerant lotion, composed of equal parts of alcohol and water, or a strong solution of nitrate of potassa and hydrochlorate of ammonia. When a sudden and powerful impression is desired, the tumor may be covered with a thin sponge, saturated with ether, or it may be irrigated with cold water, poured from a pitcher, or thrown upon it with a large syringe. Enemata of ice-water may also be tried with a prospect of success. The external application of cold must not be too prolonged, as it has sometimes been followed by gangrene, especially in the aged and infirm. However employed, it seems to do good by diminishing the congestion in the vessels of the tumor, allaying morbid sensibility, moderating the tendency to inflammation in the protruded parts, relaxing the stricture, and, perhaps, also condensing any gas that may exist in the strangulated bowel.

Warm applications are particularly soothing and useful when there is inordinate sensibility in the tumor and abdomen, along with an irritable state of the system and a disposition to nausea and vomiting. They may consist simply of water, or, what is better, of water and laudanum, kept constantly upon the parts by means of a

large, thick flannel cloth, covered with oiled silk, and renewed at least every half hour, care being taken always to have a fresh cloth ready the moment the previous one is removed. Warm applications relieve soreness and pain, and, if properly employed, relax both the parts and system, often inducing tranquil sleep and copious perspiration, during which the bowel has been known to return spontaneously into the abdominal cavity.

Although I am in favor of these applications in the milder forms of strangulated hernia, I should be very loth to employ them when there is the least urgency, or when the symptoms are such as to render the further postponement of the knife a matter of doubt. It should be remembered that they are at best merely adjuvants, and that by continuing them too long most valuable time may be lost. If, therefore, very decided amelioration does not promptly follow their employment, and, above all, if it be found, after they have been diligently applied for some hours, that the renewed efforts at the taxis are as unavailing as the previous, an operation should be performed with the least possible delay. That such a measure, however, is often necessary I am altogether unwilling to believe. On the contrary, I am satisfied from personal experience that, with the aid of anæsthesia, proper attention to the patient's posture, and a thorough knowledge of the anatomy of hernia, almost every case may be promptly relieved by the taxis. For years past I have seldom been obliged to use the knife, even where the strangulation had existed for several days, and where I had been requested by the attendant to bring my instruments for the purpose of operating. In most of these cases I have astonished the patient by the facility and promptness of the reduction, the absence of future suffering or inconvenience, and the rapidity of his recovery. It has long been the custom with some surgeons to operate in every instance of hernia after the slightest trial with the taxis, and in some of the foreign hospitals the employment of the knife seems to have become the rule, and the taxis the exception, recourse being had to it within five or six hours after the commencement of the strangulation. Such a procedure as this is certainly not justifiable when carried to such an extent, any more than too great a procrastination with the taxis.

The plan which I usually pursue, when called to a case of strangulated hernia, is perfectly easy and simple. In the first place, the patient is put thoroughly under the influence of chloroform, not ether, because this is apt to cause vomiting; secondly, the abdominal muscles are completely relaxed; thirdly, the tumor is fairly grasped with the hand, and then gently and steadily compressed, not pushed, kneaded, or squeezed by fits and starts. By the adoption of this simple method, patiently continued, I am certain that almost every hernia, however severely strangulated, may be safely and expeditiously reduced.

Sentin, of Brussels, was in the habit of practising a method of reducing strangulated hernia which he found so successful that, during the last twenty years of his life, he rarely ever employed the knife. It consists in forcibly dilating the stricture by means of the tip of the index finger, carefully insinuated into the constricting orifice, and then used as a hook, its dorsal surface presenting towards the protruding parts, while the skin of the tumor is pushed gently upwards so as not to embarrass the proceeding. The patient lies upon his back, with the pelvis raised much higher than the shoulders, and the operation is persevered in until the ring is sensibly widened, either by simple stretching or actual laceration of the resisting tissues; an effect which is generally indicated by a characteristic crack, perceptible by the finger, if not also by the ear.

The efforts of the taxis are sometimes greatly facilitated by the withdrawal of the gas and serum from the rupture by means of a delicate trocar, as originally practised by Daser, and since by Hahn, Ludwig, Blumhardt, Kern, and other German surgeons. Of 25 cases of this operation, collected by Günther, in 1861, 12 were successful, and 13 were failures. Two cases in which the reduction was promptly effected by the aid of acupuncture were reported, in 1871, by Dr. Cummins and Dr. Morton, of Louisville. Of the value of this procedure, in certain conditions, there can be no doubt. It appears to be more particularly applicable to old and large ruptures, attended with an inordinate accumulation of gas. It has, however, also been successfully applied in cases of small tumors, in which the difficulty of restoring the protruded structures was apparently due to the presence of a large quantity of serous fluid in the proper sac. The operation does not seem, in any of the above cases, to have given rise to peritonitis. The trocar should be small, not exceeding

the diameter of an ordinary exploring instrument, otherwise there will be danger of fecal extravasation. The tumor, on the escape of the gas, generally at once collapses, followed, in many instances, by the spontaneous return of its contents.

A patient has sometimes succeeded in effecting the reduction of his own hernia, after every effort with the taxis in the hands of his attendant had failed. Such an expedient is always proper if the person is intelligent, and especially if he has been in the habit of relieving himself on previous occasions.

It is well known, too, that success with the taxis is sometimes more prompt and efficient if the abdominal muscles are rendered somewhat tense than when they are completely relaxed. Indeed, some practitioners, acting upon this knowledge, invariably adopt this procedure. Turning the patient upon the side opposite the affected one sometimes answers the purpose, especially when there is much flatus, the distended bowels drawing the protruded parts backwards and upwards. In inguinal hernia the reduction is often most readily accomplished in the erect posture, the tumor being firmly grasped and manipulated by the surgeon as he stands behind the patient, the abdomen being encircled with both arms. Winslow was in the habit of placing his patients on their knees and elbows. Lastly, good effects frequently follow the inordinate elevation of the pelvis, caused by suspending the patient, as he lies in bed, partially by his feet, and doubling up his body, thus producing the greatest possible degree of relaxation of the abdominal muscles, and also a certain amount of traction of the alimentary tube above the seat of the constriction. Ambrose Paré, Covillard, and Louis all strongly advocated this method, and I have myself often employed it with the most gratifying results.

In a case reported by Mr. George Weller, of England, an inguinal hernia, the size of a small pear, was promptly reduced after repeated trials with the taxis aided by the warm bath, by pouring, unexpectedly, upon the chest and epigastrium a pail of cold water while the abdominal muscles were thoroughly relaxed and the tumor firmly grasped with the hand. The patient made a deep and quick inspiration, during which the bowel slipped into the peritoneal cavity.

When the case has been neglected, or improperly treated, the hernia sometimes suddenly disappears spontaneously, the stricture relaxing its hold during the exhaustion consequent upon the effects of the strangulation. Such cases, however, nearly always terminate fatally within a short time after this occurrence, from the joint agency of gangrene, peritonitis, and prostration of the vital powers.

In his efforts at the taxis in inguinal rupture, the surgeon or the patient may detach the neck of the sac from the surrounding structures, and, instead of restoring the hernia into the abdomen, push the entire mass—sac and its contents—intact into an artificial space between the transverse fascia and peritoneum, or, as occasionally happens in inguino-scrotal hernia, into a supplemental sac in the same situation. In a second class of cases the sac is ruptured, the rent being usually situated at the posterior surface of its neck, when the intestine escapes into the subperitoneal connective tissue. In either event the protrusion is apparently reduced, but the strangulation persists as violently as before. These accidents, which constitute the so-called reduction in mass, or "en bloc," have been particularly investigated by Luke, Blackman, and Birkett, and are well calculated to embarrass the practitioner: their occurrence is denoted by the replacement having been effected without the gurgling sound and the sudden disappearance of the tumor, so characteristic of the return of the last portion of the bowel in the ordinary reduction, by the unusually patulous condition of the rings and canal, by the absence of swelling, and by the continuance of the symptoms of strangulation. Such mishaps do not admit of delay. The proper plan, in the first case, is, to request the patient to use every possible exertion, by coughing and other muscular efforts, to reproduce the hernia, and, if he succeed in this, to proceed at once to the use of the knife. This failing, the surgeon, guided by his previous knowledge of the situation of the tumor, and the direction of the replacement, cuts down upon the parts, dividing layer after layer until he comes in contact with the dislocated viscera, which are then disengaged, and restored to their natural position. A similar procedure is adopted when the stricture exists within the hernial sac, and the protruded structures have been returned without relief of the strangulation.

Finally, it is impossible for the surgeon to be too wary in the employment of these manipulations; they must, as already stated, be made gently, not roughly, nor must they be continued too long at a time, or be too frequently repeated. The want of

proper precaution may be productive of great suffering and mischief, if not actual loss of life, from peritonitis and inflammation of the walls of the abdomen, followed, if the patient survive, by large abscesses and excessive constitutional irritation.

Cases occur in which, although the protruded structures are completely relieved of strangulation, the patient goes on from bad to worse until he finally dies completely exhausted, the vomiting, restlessness, and constipation continuing down to the time of death. The cause of this disaster usually is the constriction suffered by the bowel, or bowel and omentum, eventuating in violent peritonitis, if not in actual gangrene of the parts more immediately concerned in the accident.

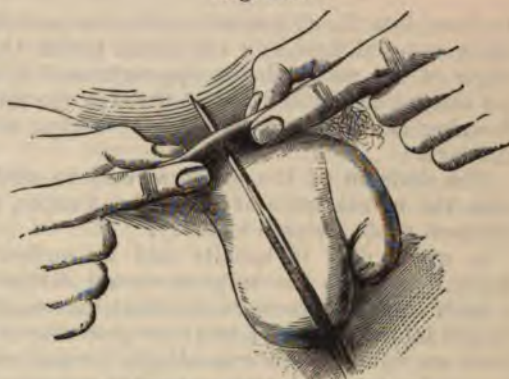
If the taxis has succeeded, the patient must not be permitted at once to rise, and go about his business, particularly if the strangulation has been at all severe. In such a case recumbency is enjoined along with light diet and a full anodyne, until all danger of inflammation is over, when, resuming the use of his truss, he may get up and walk about.

Operation.—When an operation becomes necessary, the patient is placed upon his back very much as during the taxis. The bladder having been emptied, the parts divested of hair, and an anæsthetic administered, an incision, linear, crucial, Y

or V-like, or thus, \top , \perp , ∇ ,

is made through the skin and superficial fascia, over the most prominent portion of the tumor, commencing at its upper extremity, and terminating near its base, its length varying from two to three inches, according to the size of the hernia. The integument may be divided by direct incision, or, what is generally safer, by pinching up a fold of skin, and cutting from within outwards, as shown in fig. 448. However this may be, the rule is to make a large external wound, and a small internal one. Thus, layer after layer is divided until the surgeon reaches the proper hernial sac, free use being made of the grooved director, fig. 449, in exposing the deeper seated structures. The presence of the sac will usually declare itself by its bluish, vesicular appearance; but, to dispel all doubt, a portion of it should be pinched up between the thumb and

Fig. 448.



Mode of Operating in Strangulated Hernia.

Fig. 449.



Grooved Hernia Director.

forefinger, and the opposite surfaces rubbed against each other, which cannot be done if it be anything else; or, to render the diagnosis still more certain, a puncture may be made into the part with a small needle. If this be followed by a drop of serous fluid, it will at once decide the question. An opening, just large enough to admit the point of the director, is now made, when, the instrument being carried upwards and downwards, the sac is divided to the requisite extent, followed, of course, by the escape of its contents. It should be recollected that the quantity of fluid is always small in recent strangulation, and that cases occur where it is entirely absent, lest, in our endeavors to find it, the dissection should be carried too far. The left forefinger, fig. 450, introduced into the bottom of the wound, now seeks for the seat of the obstruction at its upper extremity, and having found it a probe-pointed bistoury is carried flatwise along its palmar aspect underneath the stricture, which is immediately divided by bringing the edge of the instrument to bear against it. A little incision, not more than a line and a half in length, will generally answer the purpose. The dislocated viscera are now drawn away from the seat of the obstruction, and, being found in a condition to be restored, are next carefully

Fig. 450.



Searching for the Seat of Stricture.

Fig. 451.



Hernia Knife of Sir A. Cooper.

replaced into the abdominal cavity, the part that protruded last being reduced first, and the bowel before the omentum. The edges of the wound being approximated by several points of the interrupted suture carried through the muscular layers, the dressing is completed by adhesive strips, a compress, and a bandage.

The division of the stricture may be safely effected either with the hernia knife of Sir Astley Cooper, fig. 451, or with a common probe pointed bistoury.

A great deal is usually said by authors concerning the manner in which the surgeon should divide the coverings of a hernia, lest, by some inadvertent movement of his knife, he should injure the bowel, and thus give rise to an artificial anus. Such an injunction is exceedingly proper, as it is impossible to exercise too much caution in this respect. The anatomy of rupture is generally a bugbear with the young surgeon, and it were, perhaps, well if, after dividing the common integument, he should forget it altogether, since, if he attempt to remember the different structures described in the books, he cannot fail to be greatly embarrassed. This will be particularly the case in very recent hernias, in which the overlying tissues are frequently, if, indeed, not generally, so exceedingly thin as to force the proper sac almost in contact with the skin. In old ruptures, on the contrary, the coverings, from long-continued irritation and interstitial deposits, are usually very thick, although, as they are then very liable to be closely matted together, they are rarely very distinct.

It is almost superfluous to say that the patient should be most carefully watched after so serious an operation as that just now described. The treatment must be strictly antiphlogistic, and the probability of the occurrence of peritonitis must not be lost sight of for a moment. Much may be done in the way of prevention in most cases by the administration of a full opiate immediately after the patient has been put to bed, and by close attention to the diet and bowels, which should not be permitted to be moved for several days, but kept in the most tranquil condition possible. Should peritonitis arise, as indicated by the excessive tenderness of the abdomen, the retracted limbs, the shrunken features, and the small, wiry, and contracted pulse, the proper treatment will be venesection, leeching, anodyne fomentations, and large doses of opium. When the patient has recovered, a truss must be worn until the parts are completely consolidated, otherwise relapse will be inevitable.

Examination and Treatment of the Protruded Intestine.—In the operation as now performed, it is supposed that the protruded parts are in a fit condition to be restored to their natural situation; but cases arise where the surgeon may entertain doubts in regard to the propriety of this procedure, or where such a course would be altogether improper. Much judgment and experience are frequently required to

enable him to decide the question correctly, and to act with the promptness and certainty which should characterize his efforts for his patient's relief. On the one hand, he may return parts actually in a state of gangrene, and thus inevitably kindle the flames of a fatal inflammation; or, on the other, he may, for want of proper knowledge, cut into the bowel and excise the omentum when they are in a condition to be safely replaced. Careful inspection is generally the only reliable source of information on such occasions, but valuable aid is occasionally furnished by extraneous circumstances, as the history of the case, the small size of the swelling, the duration of the strangulation, and the condition of the system. Thus, when the hernia is small and recent, the danger of mortification is always greater than when it is large, or large and old; it is also greater when the strangulation has been protracted than when it is recent, and the probability of its existence is almost converted into certainty when, after the ordinary phenomena of strangulation, there are a Hippocratic appearance of the countenance, a feeble, tremulous pulse, hiccough, and a crackling state of the tumor, with a sudden cessation of pain and excessive prostration of the vital powers.

The hernial sac having been exposed, and the stricture divided, the parts are gently drawn down, preparatory to a thorough examination of their condition. In all cases, whatever may have been the duration of the strangulation, there will be more or less injection of the vessels of the protruded structures, rendering the former unnaturally conspicuous, and heightening the color of the latter. The vascularity of the bowel is always, in the milder forms of the accident, arborescent, that is, the vessels are spread out over the surface of the tube in dendritic lines, and the accompanying discoloration is so slight as to be scarcely distinguishable from the normal appearance; but when the constriction has been severe or long-continued, the vessels assume a capilliform arrangement, and the peritoneal lining of the intestine exhibits a claret, purple, or blackish hue, with, perhaps, here and there a slight ecchymosis. The discoloration, in either case, may be diffused or circumscribed, uniform or diversified; generally the latter.

When the discoloration is slight in degree, but more or less extensively diffused, it may be assumed that the bowel is in a condition to be returned, especially if, after having been emptied of blood, the vessels are speedily refilled. If, on the other hand, the bowel is very dark, purple, or almost black, the presumption will be strong that there has been great derangement of the circulation, if not actual stagnation of the blood, and replacement should not be attempted unless there is reason to believe that the part will be able to recover from the effects of its compression. To determine this question, one of the most serious that can arise during such an operation, the intestine, after having been thoroughly liberated, should be fomented with a sponge or cloth wrung out of warm water, and steadily maintained in contact with it for ten, twelve, or fifteen minutes; if, at the end of this time, it be found that there is no change in the appearance of the protruded knuckle, denotive of a return of its circulation, it will be proper to puncture some of its vessels, or even to scarify the bowel very slightly at a few points. If no blood issues, the probability is that the tube is mortified, a probability converted into positive certainty, if, superadded to this, there is a softened condition of the parts, an absence of all sensibility, and a total loss of temperature. Much stress has been laid upon the greenish or ash-colored appearance presented by the bowel in strangulation, but my conviction is that its importance has been greatly magnified, and that, unless it is combined with other changes, especially changes of consistence, it should not be considered as an evidence of mortification. The peculiar odor of gangrene on opening the sac is very characteristic, but is seldom present to any extent except when a large portion of bowel is devitalized. When ulceration and perforation exist, the odor is fecal.

When *mortification* has actually taken place, then, of course, the bowel is not returned, but freely opened to afford an outlet to its contents, the stricture having previously been relieved in the ordinary way. It has been objected to this procedure that it has a tendency to break up the adhesions which the intestine has formed with the edges of the hernial aperture, but such a conjecture is altogether hypothetical, and the practice founded upon it should, therefore, be disregarded. During the progress of the inflammation which precedes the mortification, the bowel is always firmly glued to the adjacent parts, and hence the incision necessary to liberate it never permits the extravasation of fecal matter into the peritoneal cavity. To leave the stricture undivided would be to afford only partial relief, not only as

it respects the symptoms of the strangulation, but also the evacuation of the tube, and might thus lead to the necessity of another operation, at a period, perhaps, when such a procedure might seriously disturb both the part and system. The wound is afterwards left open, and covered with warm water-dressing, fetor being allayed by the use of permanganate of potassa.

No surgeon, nowadays, thinks of excising the mortified portion of bowel, and uniting the tube by the interrupted suture. Such a procedure would be attended with great risk, and has, therefore, very properly fallen into desuetude. Nor is it necessary, as it was once deemed to be, to secure the bowel to the external wound by a stitch through the mesentery, since, as has already been seen, the adhesion between it and the edges in the hernial aperture is always sufficiently firm to prevent its separation, and, consequently, the occurrence of fecal extravasation into the peritoneal cavity.

It has been proposed, when the mortification is very limited, to replace the bowel instead of opening it, as when the mischief is more extensive, on the supposition that, before the slough can separate, the parts immediately around the seat of the disease will have contracted firm adhesions to the neighboring viscera, thus protecting the peritoneal cavity against fecal effusion. The propriety of such a measure may well be doubted, and I should certainly, myself, discountenance its adoption, on the ground that a dead tissue, if brought in contact with a living one, must always act as a foreign substance, and that, although it might induce a deposition of lymph on the surface in its vicinity, yet the adhesions thus formed might not be strong enough to resist either the peristaltic movements of the bowel, the efforts of the abdominal muscles, or the pressure of the abdominal viscera.

Instances occur in which the bowel is *ulcerated*, from the compression exerted upon it by the stricture. Only one opening may exist, or the part may be pierced at a number of points, not larger, perhaps, than so many pin-heads, and separated by more or less healthy tissue. In the former case, the aperture, if not more than two lines or two lines and a half in diameter, may be included in a delicate ligature tied firmly around a tenaculum, the ends being afterwards cut off close to the knot, to enable it to discharge itself into the bowel, and pass off with its contents; otherwise the part must be treated as if it were mortified. A similar practice is adopted when the intestine has a riddled, cribriform appearance; because here it would not be possible to tie up each aperture, and yet it would not be safe to return the viscus without such a precaution.

Sometimes, again, the bowel is circularly indented by the stricture, as if it had been compressed by a tightly drawn cord. In this way its circulation may be much embarrassed, if not completely suspended, followed by ulceration and even gangrene. The serous coat, possessing greater power of resistance than the others, usually retains its integrity longest, and the rule, therefore, is to return the viscus if its appearance is such as to justify the belief that it may become promptly adherent to the neighboring organs; otherwise to treat it as if it were sphacelated.

The bowel may have contracted *adhesions* to the inner surface of the sac, thus rendering its restoration difficult, if not impracticable. The mode of procedure varies according to the nature of the union, as to whether it is recent or old; in the former case, it may be easily broken up with the finger or handle of the scalpel, when the viscus, if otherwise in a proper condition, is at once replaced; in the latter, the liberation may be effected by a careful dissection, provided the adhesions are not very extensive, in which case the bowel, after having been freed by the division of the stricture, should be left in its extra-abdominal situation. When the adhesions are very firm, but limited, it has been suggested to dissect up the corresponding portion of the sac, and to return it along with the bowel; but in performing such an operation the greatest caution is necessary, otherwise the part may act irritatingly, and thus cause serious mischief.

Sometimes there is a firm and intimate adhesion between the bowel and the stricture, extending around their entire circumference, and seriously interfering with the division of the latter. The practice under such circumstances has been to incise both bowel and stricture; but this need surely never be done if proper care and patience be exercised, for by a little management the surgeon will always be able either to find, or, at all events, to make, a little opening between the parts for the insertion of his director or probe-pointed bistoury. It is only when the adhesions

old and firm that any actual difficulty can arise, and even that may always comparatively easily overcome by a little dissection.

reduction of the bowel is sometimes materially impeded, if not effectually, by an inordinate accumulation of *gas* in its interior. The difficulty will be augmented in the event of the coexistence of a large quantity of feces, or of an unusually narrow hernial canal. The proper remedy is to free the distended tube with a small bistoury, or, what is preferable, a very fine trocar, the number of openings varying from one to four, six or eight, according to the exigencies of the case. The operation, if carefully executed, is entirely free from danger, as is proved by the interesting examples observed by Köllreuter, Graefe, Ludwig, Riecke, Löffler, Dinkelacker, and other German surgeons.

Strangulated *fecal matter* may generally, with a little care and patience, be squeezed out of the incarcerated bowel, so as to admit of its gradual return to the abdomen. The operation should be performed with great gentleness, otherwise it might cause, or rupture of the bowel, at all events an undue degree of inflammation. The stricture should, of course, be freely divided, as a preliminary step. If these means fail, a small incision should be made into the intestine, and the fecal matter squeezed out, the wound, if more than a line and a half long, being afterwards closed by suture. If the intestine is distended with clotted blood, a similar course should be pursued.

Distended condition of the bowel may interfere with its ready restoration, especially if it is at the same time firmly adherent to the sac. The obstacle may generally be easily overcome by gentle manipulation.

Occasionally, serious impediment is sometimes caused by œdema of the walls of the bowel from inordinate effusion of serum, or of serum and lymph. The proper remedy is steady, systematic compression, aided by the free division of the stricture, and need be, by scarification of the peritoneal covering of the intestine.

Strangulation and Treatment of the Protruded Omentum.—Various circumstances may arise to render it improper to reduce a strangulated omentum, among which the most common are inflammation, mortification, hypertrophy, and morbid adhesions. It is well known that this body is much less capable of resisting the effects of inflammation than the intestine; hence it is, not unfrequently, in a condition not to be replaced when the other is, especially when it is loaded with fat, as it nearly always is in corpulent subjects, and when the slightest compression is almost sufficient to deprive it of its vitality. The discoloration of an inflamed omentum is always less than that of a strangulated bowel, and its vessels, instead of exhibiting an arborescent arrangement so conspicuous in the latter, usually present themselves in straggling, perpendicular lines. Conjoined with these changes, there is always, particularly in the more violent and protracted forms of strangulation, well-marked loss of consistence in the protruded part, so that the slightest pressure of the finger is sufficient to convert it into a pulpy mass.

The tests for ascertaining the vitality of a strangulated omentum are similar to those which have been described for judging of the vitality of a strangulated intestine, but it should be borne in mind, as was before stated, that a highly inflamed omentum is much more likely to die after it has been replaced than a correspondingly inflamed bowel; and hence, if its vessels are not speedily refilled after their contents have been pressed out, or the circulation does not afford evidence of increasing vigor under the use of fomentations, no attempt should be made at reduction, lest the strangulated mass, acting as a foreign substance, should induce peritonitis. Instead of this, the whole of the affected membrane is excised, and each artery is included in a separate ligature, one end of which is cut off close to the knot, and the other brought out at the wound, where it is secured by an anastomosing strip. Before so important an operation is performed, the omentum should be fully unrolled, for it occasionally happens to contain a loop of intestine, which might thus be opened by the knife, much to the detriment of the patient and the dismay of the surgeon. To prevent it from being drawn up into the abdomen after its vessels are secured, it should be firmly held by an assistant, either with forceps, a tenaculum, or a temporary ligature.

Enlargement will also be required when the omentum is much enlarged by interstitial deposits, rendering it impossible to replace it; or when, if restored, it would be liable, on account of its inordinate bulk and tuberculated surface, to cause vio-

lent peritonitis. Such a procedure is far preferable to that of leaving the protruded part in the hernial sac, in the hope of preventing thereby a recurrence of the rupture; a circumstance which, although possible, is not at all probable, and which, even if it did occur, would hardly compensate the patient for the severe dragging sensations to which he would ever after be exposed in consequence.

In strangulation of the colon, the epiploic appendages are sometimes so much diseased as to require removal. The disorder necessitating interference may be partial gangrene, as in recent cases, or hypertrophy with induration, when the hernia is of long standing. In either event, care must be taken to guard against the occurrence of hemorrhage.

An adherent omentum is treated upon the same principles as an adherent bowel, only that greater liberty may be taken with it when the attachments are old, in which case it may not only be extensively dissected away from the sac, but, if necessary, cut off, in the same manner as in mortification and hypertrophy, already described.

Hernial Abscess.—An abscess sometimes forms during the progress of a strangulated hernia, the inflammation occasioned by the constriction terminating in suppuration. Such an event is most common in hernia of long standing, attended with the formation of a large sac, and the adhesion of the protruded structures to its inner surface. The immediate cause of this occurrence may be the constriction itself, the compression of the sac by the imprisoned viscera, or, finally, some external injury, as a blow, or twist, or rough manipulation, inflicted during an attempt at reduction. The matter, which occasionally forms very rapidly, and which is generally exceedingly fetid, is of a sero-purulent character, and is sometimes quite profuse, amounting to many ounces. If the patient survives for eight or ten days, the fluid gravitates towards the most dependent portion of the tumor, where it may readily be detected by the distinct sense of fluctuation which it imparts to the fingers, by the exquisite pain and tenderness it produces on pressure, and by the red, oedematous condition of the integument. In some cases, the matter breaks through its confinement, and finds its way by ulceration to the nearest surface. I have known an abscess to form when the protruded part consisted exclusively of bowel, but the occurrence is by far most common when the hernia is omental, or omental and intestinal.

The termination of such an abscess is variable. The matter may be evacuated, and the patient make a good recovery, the parts being relieved immediately after the fluid has been drawn off, or the pus may escape into the peritoneal cavity, and cause fatal inflammation; or an opening may form externally, admitting of the discharge both of matter and of feces, as when the bowel has been invaded by gangrene; or, finally, the abscess may be emptied by puncture, but, the constriction remaining unrelieved, the patient may perish under symptoms of strangulation.

In any event, a hernial abscess is a serious complication, both as it respects the fate of the patient and the nature of the diagnosis, which is often extremely difficult and perplexing. The proper treatment, of course, is to lay the sac freely open, to evacuate the purulent fluid, to relieve strangulation, and to restore the protruded structures to their natural position.

In operating upon old strangulated ruptures, the surgeon occasionally encounters an adventitious *cyst*, or a cyst formed by the obliteration of a part of the proper sac. Its contents are either serous or bloody, and its size rarely exceeds that of a small walnut. It is generally situated at the bottom of the protruded structures, but sometimes in front, at the side, or even behind. I have met with an old strangulated scrotal hernia, which contained three distinct sacs, the lower being occupied by water, the middle by omentum, and the upper by intestine. The coexistence of so much disease is well calculated to cause serious embarrassment to an inexperienced operator.

Division of the Stricture on the Outside of the Sac.—This operation was performed for the first time in 1718, by J. L. Petit, in a case of femoral hernia, and he was so highly pleased with the result that he was induced to recommend its general adoption, especially in large and adherent ruptures, unaffected by gangrene. Opposed by his more immediate contemporaries, both on the continent of Europe and in England, it was brought forward as an entirely new proposal, in 1750, by Ravaton, with the assurance that he had employed it with complete success in three instances. The plan was zealously advocated towards the close of the last century by Professor

all such proceedings. The third indication is fulfilled by the administration of chloroform, carried to the extent of complete obliviousness. The part and system being thus thoroughly relaxed, the surgeon, standing, sitting, or kneeling, as may be most convenient, at the right side of the patient, as he lies upon the edge of the bed, the sofa, or the floor, grasps the tumor with the right hand, and draws it carefully downwards towards himself, to disengage the protruded parts from the neck of the sac, and at the same time give them the proper direction in relation to the outlet of the opening or canal through which they descended. This being done, he exerts gentle, uniform, and steady pressure upon it, to force out its contents, the left thumb and index finger being applied to the upper part of the tumor for the purpose of fixing it at that point, and thus promoting the reduction. If the hernia is very large, the manipulation is performed with both hands, with a degree of caution the greater as the force will now be likely to be more considerable. In a few minutes—perhaps only a few seconds—after the pressure has been applied, the operator will generally be conscious of a slight noise, as well as of a slight diminution of the tumor, caused by an escape of gas, and, perhaps, also of fecal matter. Steadily continuing his efforts, he finds that one portion after another of the protruded parts goes up, the last usually with a distinct gurgling sound, until the sac is completely emptied. Sometimes the most trifling pressure is sufficient for the replacement, while at other times a large amount is necessary. When the hernia consists both of bowel and omentum, the former generally ascends before the latter, although in this respect there is not a little diversity in different cases.

The length of time during which the taxis should be continued must vary according to circumstances; in general, an old hernia will, when strangulated, bear pressure much better, and also for a longer time, than a recent one, and a large than a small one. Much will likewise depend upon the amount of inflammation that may be present in the protruded viscera, the parts being always most tolerant of manipulation when this is slight, or when it exists only in a moderate degree. Then, again, a good deal will depend upon the peculiarity of each individual, one person enduring pain much better than another, although the bowel and omentum may be equally severely compressed in both. When the symptoms are urgent, it is a good rule not to continue the efforts at the taxis beyond ten, twelve, or, at most, fifteen minutes, but to proceed at once to an operation, or, what is preferable, to administer a full anodyne, and cover the tumor with some refrigerant lotion. At the end of some hours, the manipulations may be renewed, and now, perhaps, with a better prospect of success, seeing that the parts have had time to become soothed and relaxed. These attempts, however, also failing, the operation should be commenced without delay.

The taxis may be aided, in addition to chloroform, by venesection, the warm bath, anodynes, and various external applications.

Venesection, to the extent of partial syncope, has generally been viewed as one of the most valuable auxiliaries of the taxis. The blood should be drawn in a full stream, while the patient is in the erect or semierect posture, the object of the operation not being spoliative, but exhaustive. Thus performed, it seldom fails to relax the abdominal muscles, to reduce the tumor, and to prevent or relieve inflammation. Bleeding, however, is not to be resorted to indiscriminately; for, while it is exceedingly important in small and recent hernias, occurring in young, robust subjects, with a strong, hard, and frequent pulse, and great tenderness of the abdomen, it is altogether inadmissible in protracted strangulation, or in aged and debilitated persons. A small, rapid, and wiry pulse, so characteristic of peritonitis, does not contraindicate the propriety of venesection, unless there be other evidence of prostration, as coldness of the extremities, profuse perspiration, and collapse of the features. In my own practice, a resort to bleeding, as an auxiliary of the taxis, has been exceedingly uncommon, chloroform having afforded me all the aid that could be desired. When the parts are much inflamed, blood may sometimes be advantageously taken from the tumor by leeches.

The warm bath is used nearly with the same view as venesection, to depress the system, and induce relaxation of the abdominal muscles. The temperature, at the moment of the immersion, should be about 96° of Fahrenheit, from which it should be gradually raised to 110°. As soon as a disposition to faintness is felt, the taxis is renewed, and is then often successful, especially if aided by anæsthesia. Owing to the inconveniences attending its use, the warm bath is rarely employed in private

relative position of the bloodvessels. Wounding of the intestine is generally the result of sheer carelessness, but hemorrhage may occur in the hands of the most skilful operator, and may, therefore, be considered as, in some degree, unavoidable, whatever may be the precautions exercised in making our incisions and in dividing the stricture.

A wound of the bowel will be denoted by the escape of gas, feces, mucus, or ingesta, and, unless extensive, will not add materially to the danger of the operation. If it is very small, as, for instance, not more than a line and a half in length, it may be hooked up with the tenaculum, and included in a fine ligature, the ends of which are cut off close to the knot. If the incision is more extensive, the interrupted, Lembert's, or the glover's suture, must be used, as in an ordinary wound of the bowel. The tube is then replaced, and the case treated upon general antiphlogistic principles.

The hemorrhage may proceed from injury of the epigastric, obturator, or spermatic artery, and is sometimes alarmingly profuse. In operating for strangulated femoral hernia, the femoral or saphenous vein has occasionally been wounded, but such an occurrence implies great carelessness, and never happens to a skilful surgeon. When the bleeding is external, the vessel from which it proceeds may occasionally be exposed simply by everting the edges of the wound, or drawing down the neck of the hernial sac; this failing, it is sought for with the knife. The same plan is pursued when the hemorrhage is internal, the wound being enlarged, more or less freely, with the probe-pointed bistoury. Sometimes the flow of blood is readily arrested by systematic compression, made with the compress and bandage, or by means of the finger of a relay of assistants.

Lastly, the protruded parts, instead of being restored to the abdominal cavity, may be engaged in the cellular tissue between the transverse fascia and transverse muscle, where, the strangulation continuing, they may cause fatal mischief. To prevent this occurrence, the finger should always, if possible, be carried into the belly, and gently moved about to ascertain that the viscera are in their proper situation. Should this be found not to be the case, every effort should be made to liberate them; with the finger, if practicable, with the knife, if not. To leave them in their new position, would be almost certain death.

This accident is most liable to occur when an attempt is made to restore a strangulated hernia by pushing the sac and its contents forcibly through the opening in the wall of the abdomen. The plan is, in the main, a bad one, inasmuch as the surgeon is often compelled to use undue violence, in which the protruded structures may be more or less bruised and the sac even lacerated. Mr. Birkett has shown by an analysis of a number of cases that the accident is most frequent in that variety of inguino-scrotal hernia in which the parts have descended into the vaginal process of the peritoneum, owing to the great length of the sac.

Mortality.—The mortality after herniotomy must necessarily vary with many circumstances, as the mode of operating, the duration of the strangulation, the presence or absence of other maladies, the age of the patient, the nature of the rupture, and the effects of previous treatment.

1st. It has already been seen that the operation of Petit is, as a general rule, attended with much less hazard to life than that in which there is a division of the hernial sac. Of 774 cases treated according to the latter method, and collected by Mr. Gay from various sources, private as well as public, 334 died. Dr. Turner has analyzed 545 cases, of which 260 perished. Such a mortality is truly appalling; but, while it probably affords a fair average proportion in a given number of cases, it cannot be regarded as a just representation of the results of individual experience. Herniotomy shares, in this respect, the same fate as lithotomy, amputations, resections, ovariectomy, trephining, and other capital operations, some surgeons being much more fortunate than others, either because they possess greater skill, or because they are more careful in the selection of their cases.

2dly. The duration of the strangulation must necessarily greatly influence the issue, recovery being more likely to take place when the operation is performed early than late, when the patient is, perhaps, already nearly dead from shock, or shock and inflammation. All surgeons concur in the conviction that delay beyond the second day is extremely hazardous. The annexed table of Mr. Gay, slightly modified, places this subject in a very clear light.

DAY.	CASES.	RECOVERIES.	DEATHS.
1st	49	43	6
2d	41	30	11
3d	9	3	6
4th	5	2	3
5th	4	0	4
6th	7	3	4
10th	3	0	3
	118	81	37

3dly. Recovery after operation is often materially affected by the previous state of the patient's health. The existence of organic lesion of the heart, large vessels, lungs, pleura, and kidneys, especially if attended with anemia, is particularly unfavorable to success, such a condition predisposing to rapid exhaustion, and to the development of a bad form of peritonitis.

4thly. Young persons are less liable, other things being equal, to die from the effects of the operation than the old and decrepit, who often sink under its effects, especially in case of unusual delay.

5thly. The mortality of strangulated femoral and umbilical ruptures is, on an average, considerably greater after operation than that of inguinal hernia, but in what ratio has not been determined.

Finally, the results of herniotomy are often materially influenced by the effects of the previous treatment. Rude and protracted manipulation cannot fail to be prejudicial, from its tendency to provoke peritonitis, and there is no doubt that many a patient has been killed by tobacco injections, the hot bath, and excessive venesection, although the operation itself may have been well performed.

Causes of Death.—The principal causes of death after herniotomy are shock, hemorrhage, peritonitis, erysipelas, and pyemia.

1st. Fatal shock after this operation is uncommon. It is most frequently witnessed in old, dilapidated subjects, exhausted by the long continuance or severity of the strangulation, and occasionally occurs where there is not the slightest evidence of constriction of the bowel, pressure upon the omentum alone being capable of producing it.

2dly. Loss of life from hemorrhage after herniotomy is infrequent; for the surgeon, as already stated, seldom divides any important artery in his attempts to uncover and liberate the protruded parts; and, when the accident occurs, he is generally able to secure the vessel before the patient has sustained any serious detriment.

3dly. The most common cause of the fatality after this operation is undoubtedly peritonitis. This disease, in fact, generally exists, to a greater or less extent, in all cases of strangulated hernia prior to the operation, and it is, therefore, not surprising that it should often be materially aggravated by the use of the knife and finger, especially when the sac is laid open, by the contact of inflamed with healthy peritoneum after the reduction of the parts, or by the escape of fecal matter, as sometimes happens in ulceration of the bowel. When death arises from peritonitis, however induced, it usually takes place within the first three or four days after the operation.

4thly. A bad form of erysipelas not unfrequently comes on after this operation, generally during the first thirty-six hours, being most common in persons of broken constitution and intemperate habits, and in such as are laboring under organic disease of the heart and kidneys. The attack manifests itself by a reddish or livid appearance of the parts, soon followed by gangrene and sloughing, or, at all events, by a foul, unhealthy condition of the wound, and by great irritability and depression of the system. The period at which it proves fatal varies, on an average, from three to five days.

5thly. Pyemia, as a cause of death after herniotomy, is of rare occurrence. It is most liable to arise in persons who have suffered severely from the shock of strangulation, or from shock and hemorrhage, and usually comes on within the first three days after the operation.

Finally, death is occasionally produced by the rude employment of the taxis, in consequence of the imperfect division of the stricture, or the adhesions of the protruded parts to each other and to the hernial sac. An accidental wound or rupture of the intestine may be cited as another cause of fatality.

Age is no bar to the success of an operation for strangulated hernia. It has often been performed upon very old persons, and, on the other hand, cases have been re-

ported in which it was performed upon very young children. Thus, Curling has recorded an instance of twenty-one months, Rayner of seven weeks, and Fergusson of seventeen days. The operation in very young children is supposed to be more liable to be followed by peritonitis, but, if this be so, the assertion needs proof. In the cases observed by Curling and Rayner the success was most gratifying.

Of 48 cases of strangulated hernia, nearly all of the inguinal variety, during the first and second years of infancy, collected in 1868, by Dr. E. W. Wimer, 26 were operated upon with a loss of 8, 18 were reduced by taxis with 3 deaths, and 3 were treated therapeutically with 1 fatal issue.

Old Hernial Sacs.—An old hernial sac, long freed of its contents, may, by becoming inflamed, cause symptoms closely simulating those of an ordinary strangulated hernia, especially when it retains its communication with the general peritoneal cavity. The suffering will be less marked when this connection has been destroyed, the pouch forming a shut sac filled with serum, pus, or blood.

This variety of hernia, sometimes called *pseudo-hernia*, is more liable to strangulation in women than in men, and in the femoral than in the inguinal region. The tumor is generally small, not exceeding the volume of a pullet's egg, of a rounded or ovoidal figure, and of a tense, slightly elastic consistence. When of considerable bulk, and not too firmly bound down, it may impart a distinct sense of fluctuation. In cases of doubt, the parts should be punctured with a fine needle. An escape of serum, pus, or blood will generally at once determine the diagnosis. When the uncertainty continues, with the symptoms of strangulation unabated, the rule is to operate, as no harm can result from exposing the tumor, whatever may be its character. It is a singular fact that most of the patients in whom this *pseudo-hernia* has been observed wore trusses at the time of the occurrence of the strangulation, and were, apparently, unconscious of the nature of their complaint.

When a hernial sac of this kind becomes inflamed, relief should be attempted by antiphlogistic means, especially leeches and refrigerant applications; these failing, the parts should be carefully exposed, and all sources of constriction removed. When the tumor consists of a shut sac, filled with serum, the proper plan will be to lay it freely open, and to mop its surface thoroughly with dilute tincture of iodine, in the hope of thus effecting its obliteration. Excision of such a sac, although not necessarily fatal, would be hazardous, inasmuch as it might provoke severe, if not destructive inflammation. Moreover, in the event of recovery, the operation might be followed by a redescend of the viscera, by breaking up important adhesions.

SECT. II.—HERNIA OF PARTICULAR REGIONS.

The principal varieties of hernia are the inguinal, scrotal, femoral, and umbilical, to which may be added the rarer forms of obturator, sciatic, perineal, pudendal, vaginal, and diaphragmatic.

INGUINAL HERNIA.

When the contents of the abdomen pass out at the groin, the complaint constitutes what is called an inguinal hernia, or a rupture of the groin. Of this affection there are, as seen in fig. 452, two distinct varieties, first accurately described, in 1806, by Hesselbach, and respectively known as inguinal hernia by the oblique descent, and inguinal hernia by the direct descent.

Inguinal hernia, in both of its forms, is much more common in men than in women. Of 39,419 cases treated by the London Truss Society, 38,322 occurred in males, and only 1097 in females.

These two varieties of hernia occasionally, although very rarely, coexist on the same side of the body, as in the remarkable case recorded by Dr. Chiene, of Edinburgh. The tumors had descended through the external inguinal ring, and were separated from each other by a well-marked ridge formed by the epigastric artery, the length of one being two, and of the other three inches.

Oblique Inguinal Hernia.—Oblique inguinal hernia derives its name from the fact that it pursues the course of the spermatic cord in the male, and of the round ligament in the female. It is of more frequent occurrence than all the other varieties of the complaint put together; is met with chiefly in men, and is more common on the right side than on the left. The reason why this form of hernia is so much more

frequent in men than in women is the greater relative size of the inguinal rings and canal in the former than in the latter, thus constituting a powerful predisposition to the disorder. Another reason, doubtless, is that men are much more exposed to all kinds of hardships, involving inordinate muscular exertion. The situation of the liver has usually been assigned as the cause of the greater frequency of hernia on the right side than on the left, the pressure which it exerts upon the alimentary tube, and through it upon the inguinal region, being much greater than that exerted by the spleen. As another cause of the difference, although probably not a very efficient one, may be mentioned the circumstance that most persons are right-handed, thereby keeping the right abdominal walls more constantly in a state of tension, especially in the working classes, among whom inguinal hernia is so common. The affection is produced by the same causes as ruptures in other situations, and may be complete or incomplete, according as the parts protrude or not at the external ring.

Age exerts a marked influence upon the production of this variety of inguinal hernia. Of 300 cases, analyzed by Malgaigne, 22 occurred before the end of the first year, 7 from the first to the fifth year, 15 from the fifth to the tenth, 26 from the tenth to the twentieth, 45 from the twentieth to the thirtieth, 66 from the thirtieth to the fortieth, 42 from the fortieth to the fiftieth, 36 from the fiftieth to the sixtieth, 30 from the sixtieth to the seventieth, and 11 from the seventieth to the eighty-ninth.

In complete oblique inguinal hernia the viscera enter the internal inguinal ring, and, descending along the inguinal canal, emerge at the external ring, forming thus a tumor in the groin, immediately above Poupart's ligament, and just outside of the spine of the pubes. Varying in volume from that of a pigeon's egg to that of the fist, it is usually of a globular form, and of a soft consistence, receiving a distinct impulse on coughing, and receding during recumbency, but reappearing in the erect posture.

There is a peculiar form of inguinal hernia, accompanied by an undescended testicle, in which the tumor extends uncommonly far outwards and upwards towards the crest of the ilium. In a case under my charge, in a man, thirty-five years of age, at the Philadelphia Hospital, the tumor was of extraordinary volume, measuring twenty-two inches in circumference at its attachment to the abdomen, by nine in length, and ten in width. It was of a globular form, and hung down over Poupart's ligament, on the right side, as far nearly as the upper third of the thigh, reaching, on the one hand, over to the pubic symphysis, and, on the other, to the anterior superior spinous process of the ilium. It was soft, elastic, and easily reducible, the parts returning with a gurgling noise. The opening through which the bowel had descended appeared to be upwards of an inch in diameter, and to correspond with the internal ring. The testicle lay at the outside of the tumor, between the inner ring and the anterior superior spinous process of the ilium, and was remarkably sensitive to the touch, but of the usual size. The left testicle was also retained in the groin, occupying the site of the internal ring. The scrotum existed in a rudimentary state. The hernia had come on five years previously, in consequence of a strain, and had of late greatly increased in bulk. The tumor exhibited altogether a very remarkable appearance. There is no doubt that the protruded viscera in this case would have passed into the scrotum, if their progress had not been impeded by the undescended testis, which had the effect of pushing them upwards and outwards.

Although an undescended testicle appears to be the most common cause of this peculiar form of hernia, a similar occurrence is sometimes produced by a badly-adjusted truss, as when the pad, resting solely upon the external inguinal ring, permits the bowel to descend into the inguinal canal, from which, owing to the resist-

Fig. 452.



Inguinal Hernia; on the Right Side Oblique, on the Left Direct. *a.* The Hernial Sac. *b.* The Epigastric Artery.

ance thus offered, it is gradually deflected outwards in the direction of the ilium, away from the ordinary course of this variety of rupture.

Should such a hernia become strangulated, the proper mode of procedure would be to draw the contents, at first downwards and inwards, and afterwards upwards and outwards, in the direction of the internal ring.

An instance of oblique congenital inguinal hernia in a man twenty-seven years of age, has been described by Mr. W. J. Wilson, in which an oval mass of omentum inclosed in a sac, with a contracted neck, occupied the natural position of the testicle, which was retained in the inguinal canal.

A double oblique inguinal hernia occasionally occurs on the same side of the body. One such case has been described by Bransby Cooper, and examples of a similar character are reported by other writers.

Diagnosis.—The diagnosis of this variety of hernia may be obscured by various affections liable to occur in this situation, among which the most common are hydrocele of the spermatic cord, imperfect descent of the testicle, diseased lymphatic glands, and psoas abscess. An oblique inguinal hernia, so long as it remains in a reducible state, may, in general, be easily distinguished from other affections; but the case is very different when it becomes irreducible or strangulated. Then the most experienced surgeon cannot always determine, without the greatest care, the precise nature of the complaint.

An encysted *hydrocele* of the spermatic cord is generally small, not exceeding the volume of a pigeon's egg, round or ovoidal, tense and elastic, uniform in its consistence, fixed in its situation, and distinctly translucent when viewed against the light. These characters, together with its history, are sufficient to distinguish it from hernia, provided it is below the external ring, but when it is above this point, under cover of the tendon of the external abdominal muscle, some difficulty may be experienced. When this is the case, a small exploring needle will generally furnish the requisite information.

An imperfectly descended *testis* might be mistaken for an oblique inguinal hernia, especially if it were to lie, as it sometimes does, partly within and partly outside the external ring. Its ovoidal form, however, its constant, unvarying volume, its firm consistence, and the peculiar sickening sensation produced by compressing it, together with the history of the case, and the absence of all disturbance of the intestinal tube, will hardly admit of the possibility of confounding the two complaints with each other. The character of the gastric symptoms often affords valuable diagnostic aid. In strangulated hernia the vomiting, as remarked by Paget, is free, but there is comparatively little nausea, whereas in an inflamed undescended testicle the nausea is constant, and the vomiting comparatively slight. The necessity of a thorough examination of the scrotum in all cases of doubt is sufficiently obvious.

An inguinal hernia is sometimes closely simulated by an inflamed *lymphatic gland*, and the diagnosis may be still further embarrassed by the coexistence of the two diseases. Such an enlargement may result from various causes, of which, however, the most common are gonorrhœa and chancre, leading often to a great deal of tenderness, pain, and swelling, followed, in time, by suppuration and abscess. In the early stage, the affection might be mistaken, especially by an incautious observer, for an inguinal rupture. In general, the enlargement is easily recognized by its situation, which is oftener below than above Poupart's ligament, by its defined, circumscribed character, by its mobility, and by our being able, when the tumor is grasped, to lift it away, as it were, from the subjacent parts; circumstances which, joined to the history of the case, will usually serve to show that the tumor is not a hernia.

Another source of doubt in this affection is *psoas abscess*, which, as it progresses, often points just above Poupart's ligament, generally, however, nearer to the anterior superior spinous process of the ilium than to the pubic symphysis, which is not the case in complete inguinal hernia, whether by the oblique or direct descent. In psoas abscess, moreover, the patient is always somewhat lame on the corresponding side, and there is more or less derangement of the general health prior to the occurrence of the doubt in the diagnosis. Besides, in strangulation the tumor is fixed, whereas in psoas abscess it is movable, receding under pressure, and disappearing measurably or completely during recumbency.

Finally, inguinal hernia may be confounded with an abscess of the groin, developed

in the course of the spermatic cord, as occasionally happens in inflammation of the cellular substance of this body; or, instead of this, the matter may proceed from the cavity of the peritoneum, enter the sheath of the spermatic cord, and point, externally, at the abdominal ring. The diagnosis is established upon the same principles as in psoas abscess.

Sometimes a psoas abscess and an inguinal hernia may seem to coexist, when, in reality, there is only an abscess, part of the contents of which, making its way into the spermatic canal, appears at the external abdominal ring, forming a swelling similar to a bubonocoele.

Anatomy.—In oblique inguinal hernia the *spermatic cord* is situated behind the tumor, the epigastric artery lying on its inner side, close to its neck. As it proceeds downwards to its place of destination in the groin, it clothes itself, in addition to its proper sac, with the infundibuliform process of the transverse fascia, the fibres of the cremaster muscle, the spermatic fascia, superficial fascia, and skin. Hence, every such hernia may be said to have six coverings, which, in cases of long standing, are generally quite thick and closely matted together, but often very thin, and indistinct in those of recent formation. I recollect operating, some years ago, upon a strangulated inguinal hernia, where the coverings of the tumor consisted only of the skin and the merest film of cellular tissue. In old ruptures, on the contrary, especially in those of large bulk, a tedious dissection is often necessary before the proper sac is reached, skin, fascia, muscular and aponeurotic fibres being all in a state of thickening, induration, and condensation from interstitial deposits.

In a recent oblique inguinal hernia, the *internal ring* occupies its accustomed situation, midway between the anterior superior spine of the ilium and the pubic symphysis, about four lines above Poupart's ligament, and this, therefore, is the point where the pad of the truss is to rest in the reducible form of the affection; but in cases of long standing and of great bulk, the opening undergoes important changes in its relative position, being dragged down just behind the external ring, the intervening canal itself being effaced. The ring, moreover, under these circumstances, is generally very much enlarged, and of an annular form, so as to admit very readily the extremity of a big finger. A knowledge of these changes is of the greatest importance both in relation to the taxis and the operation for strangulated hernia.

The *contents* of this variety of hernia usually consist of a knuckle of the ileum, either alone, or in union with a portion of omentum; sometimes of the arch of the colon, and occasionally of the caecum, the sigmoid flexure of the colon, and of the urinary bladder. The disorder may coexist with inguinal hernia by the direct descent, femoral hernia, or umbilical hernia. In one case an inguinal and a femoral hernia were found on each side of the same person.

Treatment.—For the reducible oblique inguinal hernia a well constructed truss is used, the pad being of an ovoidal shape, arranged obliquely in reference to its spring, and applied in such a manner as to compress the internal ring. The precise point

Fig. 453.



Double Truss.

Fig. 454.



Truss Applied.

upon which, in recent cases, the pad should rest is about four lines above the centre of Poupart's ligament. In cases, however, of long standing, where the two openings are on the same plane, the pressure must obviously be made lower down, as well as farther in towards the median line, or, to speak more definitely, directly in the situation of the outer ring. The block, too, should be somewhat larger, in order that its influence may be more widely diffused. In the symmetrical form of hernia a double truss will be required, and one of the best for this purpose is that

delineated in fig. 453, with two pads in front and two behind, to equalize the pressure both upon the part and trunk.

The best retentive truss for ordinary inguinal hernia, whether by the oblique or direct descent, that I am acquainted with, is the one depicted in fig. 454. The pad is of an elongated, ovoidal form, and is so arranged as to adapt itself most thoroughly to the groin and thigh, to which it is still further secured by means of a soft buckskin strap. The spring extends as far as the spine, where it is connected with a band carried around above the opposite hip, and fastened to the pad in front. The apparatus is particularly suitable for cavalymen, mechanics, and laborers, who are obliged to perform varied and sudden movements and contortions of the body, as it does not relinquish its grasp upon the parts.

The irreducible oblique inguinal hernia is treated upon the general principles laid down in the previous section, care being taken to give due support to the parts by means of a suspensory bag, or a hollow truss, worn day and night. In this way the hernia is prevented from increasing, at the same time that it is measurably protected from harm.

In the event of strangulation occurring in this variety of hernia, the taxis is to be employed in strict conformity with the direction of the descent. Thus, in recent cases, where the rings retain their natural position, the parts are pushed obliquely upwards and outwards, in the course of the inguinal canal; whereas, under opposite circumstances, the pressure is made directly upwards, or upwards with a slight inclination outwards. Unless the strictest attention be given to these rules, the surgeon may find it extremely difficult, if not impossible, to attain his object. In regard to the position of the patient, it should be in strict accordance with the instructions laid down under the general observation upon this subject.

The diagnosis between hernias by the oblique and direct descent is by no means always easy. In recent cases, it is often possible to insinuate the point of the finger for some distance into the opening of descent, so as to leave little, if any, doubt as to whether the bowel has followed the course of the spermatic cord, or has been pushed down immediately behind the external ring. In old hernias, on the contrary, the discrimination is often attended with difficulty. Under such circumstances, in rupture by the oblique descent, the two rings, as previously stated, are always situated in close contact with each other, owing to the complete effacement of the intervening canals, and, when this is the case, no examination, however skilfully conducted, can determine the original direction of the descent. If the tumor, however, should be of extraordinary bulk, as when it equals or exceeds the volume of a foetal head, it may be assumed, as a general rule, that the hernia has been one by the oblique descent; for it seldom happens that an internal, direct, or ventro-inguinal rupture attains very great size. In congenital hernia, whether the tumor is retained in the groin or prolonged into the scrotum, the descent is almost always, if not invariably, oblique, or, in other words, in the direction of the spermatic cord.

Should the taxis fail, and an operation become necessary, the stricture will generally be found to be at one of three situations; at the internal ring, within the canal at the edge of the transverse and internal oblique muscles, or at the external ring. In old and large hernias, the obstruction is usually at the latter point, whereas, in small and recent, it is commonly at one or the other of the former. However this may be, the finger will always readily detect it as soon as the proper sac has been sufficiently exposed to receive it. In dividing the stricture, where no doubt exists as to the precise nature of the descent, the direction in which the knife should be carried is obvious enough, being in the one case obliquely upwards and outwards, and in the other directly upwards; but when it is uncertain whether the hernia was originally one by the oblique or straight descent, the safest rule, as it respects the epigastric artery, is to cut directly upwards, inclining the knife neither to one side nor to the other. For, should the hernia be one by the direct descent, and the surgeon carry his instrument upwards and outwards under the idea that the protrusion is oblique, he would almost inevitably injure the vessel in question, and thus lead to a very embarrassing, if not fatal, hemorrhage. The rule here indicated, then, should be most scrupulously observed in all cases of doubt.

The direction of the external incision must vary according to the nature of the descent, and may be simply a linear one, as when the tumor is very small, or T-like, curvilinear, or crucial, if it be large. The dressings and after-treatment are in every respect the same as under ordinary circumstances.

In operating upon inguinal and scrotal hernias, it is important to remember that there are certain varieties of these affections in which the sac is either incomplete or altogether absent. This arrangement, as was before stated, is owing simply to the peculiar nature of the contents of the rupture. Hernia of the cæcum affords the best example of the absence of serous investment. This division of the large bowel, situated in the right iliac fossa, has no serous covering behind, and hence, when it is dragged down into the inguinal canal, its cellular surface may be found directly under the knife, and the tube be in danger of being opened, the surgeon supposing that he is cutting through one of the envelopes of the rupture. A similar arrangement occasionally occurs in inguino-scrotal hernia, containing a portion of the sigmoid flexure of the colon, in which the adherent surface of this portion of the bowel lies immediately beneath the outer coverings of the tumor. In some forms of hernia of the bladder, it is not improbable that that portion of this organ which is naturally uncovered by peritoneum might present itself to the knife, and, unless great care be taken, be laid open. In most cases, the protruding organ would be likely to exhibit, at least in part, the usual glistening surface so characteristic of a peritoneal investment.

Incomplete Oblique Inguinal Hernia.—The incomplete inguinal hernia has received different names, expressive either of its situation or of its obscure character, as interstitial, interparietal, and concealed. The term incomplete is, perhaps, as proper as any other, and may, therefore, be employed to their exclusion, the more especially as we shall thus remove one source of confusion.

In this variety of hernia, which is merely a subdivision of that just described, the abdominal viscera pursue the same course, only that they do not pass out at the external ring; indeed, very frequently they do not even descend nearly so low down. I have seen several instances where the hernia consisted of less than one-sixth of the diameter of the bowel, which projected scarcely a third of an inch into the inguinal canal, and which, consequently, did not form the slightest appreciable tumor in the groin. Such an occurrence is always peculiarly dangerous, from its great liability to be overlooked when it becomes strangulated. In the cases adverted to, all the patients perished from this cause. Dissection revealed the existence of severe peritonitis and a stricture just within the inguinal canal. In two of the cases, the stricture had been formed by the edges of the internal ring.

A case recently occurred at the Pennsylvania Hospital, under the care of Dr. Hewson, in which the protruded part consisted exclusively of the vermiform appendix, the extremity of which had been opened by gangrene, so as to admit of the passage of a probe into the cæcum.

In general, however, the protrusion is more voluminous, and often consists both of bowel and omentum, passing down some distance into the canal, and forming a well-marked prominence externally; liable to be mistaken for encysted hydrocele of the spermatic cord, psoas abscess, or an imperfectly descended testicle, and, when strangulated, tender under pressure, painful, resisting the taxis, and attended with great constitutional distress. The mode of determining the diagnosis is similar to that of ordinary oblique inguinal hernia, but additional solicitude should be felt when, if strongly-marked symptoms of strangulation exist, there is no tumor in the inguinal region, or in any of the usual sites of rupture. In such a case, the most thorough scrutiny should be instituted, and it will be well, if there be no outward evidence of the affection, to put the patient in the proper position for the taxis, and to use the same means for effecting reduction as if we were positively assured of the presence of hernia. I should, in such an event, place no little reliance upon any tenderness that might be discovered at or near the internal ring, as a guide to the course to be pursued for the relief of the patient. Even if it were only slight, but circumscribed, a judicious surgeon would hardly hesitate, especially when everything else is clearly denotive of the existence of strangulation, to use the knife, well knowing that no great harm could result from it, even if the operation proved to be a failure; whereas, if a hernia really existed, it would be the only proper procedure after a fair trial of the taxis.

The coverings of this variety of hernia are, examining the parts from without inwards, the skin, superficial fascia, tendon of the external oblique muscle, cremaster muscle, and infundibuliform process of the transverse fascia, together with the proper sac. The stricture is usually formed by the edge of the internal oblique and transverse muscles, and should be divided by carrying the knife obliquely upwards and

outwards, as it will thus effectually avoid the epigastric artery, which always lies on the inner side of the tumor. When the included portion of bowel is very small, the seat of the constriction will generally be at the internal ring or at the mouth of the sac. The spermatic cord always bears the same relation to the protruded parts as in complete oblique inguinal hernia.

Direct Inguinal Hernia.—Inguinal hernia by the direct descent, or ventro-inguinal hernia, as it is sometimes denominated, is comparatively infrequent, especially in the female, in whom it is so rare that many surgeons, even in large practice, never see an instance of it. Possibly it may be more common than is supposed, but being difficult of diagnosis, it may not always, or, perhaps, even ordinarily, be in our power to distinguish it from the oblique form of the complaint. The reason why women are so seldom affected with ventro-inguinal rupture is, the small size of the rings and canal, as compared with those of the male, and the greater amount of resistance which these parts are consequently capable of affording to the protrusion of the abdominal viscera.

In this variety of rupture, the viscera descend immediately behind the external inguinal ring, passing either below the transverse and internal oblique muscles, or through an opening, usually somewhat slit-like, in their fibres. The epigastric artery and the spermatic cord lie on the outside of the sac, although occasionally, in exceptional cases, the latter is placed in front or even on the inside of the tumor. Its coverings consist of the skin and superficial fascia, the spermatic fascia, some of the fibres of the cremaster muscle, a prolongation of the transverse fascia, and, lastly, of the proper sac. Sometimes a few straggling fibres of the transverse and internal oblique muscles are sent down over the tumor, and thus serve to give it a partial investment. The tumor is of the same form and consistence as in oblique inguinal hernia, but seldom so large, and is distinguishable from other affections of the groin in the same manner. It is usually composed of bowel alone, the omentum entering less frequently into its formation than in the more common variety of inguinal rupture.

In employing the truss for the relief of this form of hernia, care must be taken to apply the pad directly above the external ring, at a point considerably further down and inwards than in a recent oblique hernia. When strangulation occurs, the parts are pushed directly upwards and backwards, or, if the tumor be small, directly backwards, the same precautions being observed in regard to the position of the body and limbs of the patient as in the other varieties of inguinal hernia. Should an operation become necessary, the stricture will be found either at the external ring, or at the inferior edge of the transverse and internal oblique muscles, and is to be relieved by carrying the knife directly upwards, to avoid injury to the epigastric artery which lies on the outside of the tumor. This precaution is so much the more necessary, inasmuch as it is not always in our power to determine whether the rupture is one by the direct or oblique descent. Thus, if the surgeon, in dividing the stricture, were to incline the knife inwards, under the supposition that he had to deal with a direct hernia, but which proved to be an oblique one, the result would almost inevitably be a wound of the vessel under consideration; hence, in order to avoid such a contingency, the best plan, in all cases, is to carry the instrument directly upwards, without any lateral deviation whatever.

Inguinal Hernia in the Female.—When the viscera project from the inguinal canal into the labium, so as to constitute what is termed inguino-labial hernia, an exceedingly uncommon form of rupture, the descent is generally oblique, the parts following the course of the round ligament of the uterus. Hence the epigastric artery will usually be found to be on the inner side of the tumor, as in oblique inguinal hernia of the male.

The coverings of this variety of hernia consist of the skin, superficial fascia, inter-columnar aponeurosis, transverse fascia, and peritoneum, the latter forming the proper sac. The cremaster muscle is, of course, wanting. The round ligament lies behind the sac, except in the direct descent, when it is at its external aspect. The tumor is generally very small, but in a case described by Mr. Alexander Watson, of Edinburgh, it was of enormous bulk, containing not less than twelve feet of small, and two of large, bowel.

This rupture, as that of the male, may be complete or incomplete. The former generally contains intestine and omentum, but cases occur, as those observed by Sir Astley Cooper, Hesselbach, and others, in which it includes the ovary and Fal-

loping tube. In the incomplete variety, the parts are retained under the aponeurosis of the external oblique muscle, forming a small, oval tumor not always easy of detection.

The diagnosis of inguinal hernia is occasionally obscured by the existence of a *serous cyst*, formed, apparently, in connection with the canal of Nuck, a process of peritoneum, extended over the round ligament. The tumor, which is sometimes prolonged into the labium, is free from pain, slow in development, semipellucid, globular, ovoidal or pyriform, elastic, fluctuating, and filled with a thin, watery fluid, similar to that of hydrocele. Its volume ranges between that of an egg and a large fist. In a case mentioned by Scarpa, the cyst, attached by a narrow pedicle, was fourteen inches in circumference, and contained forty-three ounces of fluid.

SCROTAL HERNIA.

Scrotal hernia is, strictly speaking, merely a form of inguinal hernia, the abdominal viscera, instead of stopping in the groin, passing down into the scrotum. The difference, it will thus be perceived, is one altogether of degree, not of kind. The affection, although sometimes congenital, is most commonly acquired, or brought about under the influence of muscular exertion, elderly subjects being most liable to it. The contents of the hernia, which is occasionally double, are various; consisting at one time of bowel alone, at another of omentum alone, and in a third series of cases, and these are, perhaps, the most frequent, of the two conjoined, the former in this event always lying behind the latter. The shape of the tumor is generally ovoidal, or pyriform, but instances occur in which it is cylindrical, globular, conical, or hour-glass like. Its volume is occasionally enormous. In a case which I treated some years ago it was twelve inches in length, and nearly two feet in circumference at its widest part, which was at its middle. In another case the tumor was still larger, descending nearly as low down as the knee, and being of a proportionate diameter. As a general rule, it may be stated that the size of the rupture is much less when the disease is the result of the direct descent than when it is caused by the oblique. Whenever the hernia is of unusual bulk, the penis is either partially or completely buried in its substance, thus interfering with copulation, and even with micturition. Whatever may be its form and size, the testicle is situated at its base, the spermatic cord being at its posterior surface. The ordinary appearances of a scrotal hernia are well depicted in fig. 455, from a patient at my clinic.

Large scrotal hernias are almost always irreducible, or, if they are not so originally, they are almost sure to become so ultimately. I have seen one case, however, in which a double rupture of this kind, of large size, remained reducible at the end of forty years. The most common causes of this occurrence are plastic adhesions between the protruded parts, or between these and the inner surface of the sac; but it happens also not unfrequently from a kind of sarcomatous enlargement of the omentum, interfering with its return through the inguinal rings. A hypertrophied state of the bowel itself is another circumstance that may render such a hernia, originally reducible, in time irreducible. However this may be, the patient generally experiences dragging sensations and colicky pains in the abdomen, and the bowels are almost always habitually constipated. The tumor is firm, but somewhat elastic to the touch, and quite tolerant of manipulation, except when inflamed or irritated by exercise.

A large irreducible omental hernia occasionally produces such an amount of pressure as to cause enlargement of the testicle and spermatic cord, effusion of serum into the vaginal tunic, or suppuration of this membrane, followed, now and

Fig. 455.



Scrotal Hernia.

then, by an extension of the inflammation to the peritoneum, and the death of the patient.

The coverings of an old scrotal hernia are often very thick, dense, and firm, and not easily distinguishable from each other in case of an operation. The proper sac lies in immediate contact with the vaginal tunic of the testicle, and, in order to reach it, it is necessary to divide, in addition to the skin, the dartos, which answers here to the superficial fascia, the spermatic fascia, the cremaster muscle, and the infundibuliform process of the transverse fascia. No vessel of any importance is involved in its anatomy; in old and large scrotal hernias, however, the external pudic artery is often much enlarged, and consequently capable of furnishing a considerable hemorrhage.

Occasionally the testicle, instead of being hypertrophied, is greatly reduced in size, if, indeed, not completely wasted. Irregularity of situation is also sometimes met with. Thus, in a case under my care in 1858, where the tumor was of extraordinary bulk, and had long been irreducible, the testicle was seated at the side of the swelling, a short distance below its middle.

Diagnosis.—Scrotal hernia is liable to be confounded with other affections, particularly with hydrocele, varicocele, and sarcocele, chiefly, however, in its earlier stages; for, when the complaint is well established, it is almost impossible to mistake its real character, except by the most superficial examination.

From *hydrocele* it may generally be easily distinguished by the following circumstances. Hernia always begins above, showing itself, in the first instance, as a tumor in the groin, from which it gradually descends into the scrotum. In hydrocele the reverse is the case, the swelling commencing below, and gradually extending upwards. In hernia the tumor is irregular in shape, and generally more or less flattened in front and behind; whereas in hydrocele it is usually pyriform, being larger below than above. In hernia the testicle is at the bottom of the tumor, while in hydrocele it is at its posterior surface, commonly above the junction of the inferior with the two superior thirds, although this arrangement is by no means constant; for in many cases of hydrocele the organ lies at the base of the swelling. In hernia the tumor is doughy, or gaseous, not elastic and fluctuating as in hydrocele; opaque, and not translucent; in the former the patient usually experiences disagreeable

dragging sensations and colicky pains, especially when the protrusion is very large; while in the latter he suffers no inconvenience save what results from the volume and weight of the swelling. In reducible hernia, the contents of the tumor are easily replaced when the patient is recumbent, but redescend the moment he resumes the erect posture; while in hydrocele no such changes can possibly occur, whatever may be the posture. When we add to these symptoms the fact that the spermatic cord is always behind the protruded parts in hernia, and, consequently, much less distinct in its outline than in hydrocele, in which it may almost always be felt as a firm, rounded body at the upper extremity of the tumor, and the circum-

Fig. 456.



A Scrotal Hernia; showing the Usual Relation of the Sac to the Vaginal Tunic.

stance that the opening through which the rupture has taken place may always be satisfactorily traced with the finger, while in hydrocele the inguinal rings retain their natural form; there will be no difficulty, at least in the majority of instances, in arriving at a correct decision. Much valuable information may also be derived from the history of the case, and from the use of the exploring needle, which, whenever there is any doubt, will not fail to afford the requisite light.

Scrotal hernia and hydrocele not unfrequently coexist, constituting a combination which it may be extremely difficult to distinguish from each other. The best guides are the history of the case, and the phenomena which ordinarily characterize the two affections when occurring separately. When the diagnosis is very obscure, useful information will be furnished by the introduction of a very delicate exploring needle.

In most of these cases the hydrocele is formed first, and, consequently, occupies the lower part of the scrotum, being separated from the hernial sac by a kind of hour-glass constriction. Sometimes, however, the two tumors are insensibly blended together; and instances are observed—perhaps more frequently than is generally supposed—in which the hydrocele is situated directly in front of the rupture; so that, if an operation should be required, it would be necessary, in order to reach the seat of the stricture, to carry the knife across three distinct layers of serous membrane, the most deep-seated being the proper hernial sac. Such a condition is most frequent in advanced age, in connection with old, bulky ruptures. The complication may be limited to one side, or there may be as many as four tumors, although this is very uncommon.

Scrotal hernia may always be readily distinguished from *varicocele* by the peculiar feel which the enlarged veins in this disease impart to the finger, which is similar to that of a bundle of earth-worms, or of the intestines of a squirrel; by the bluish appearance of the tumor; and by the circumstance that the swelling, after being effaced, is always promptly reproduced when the patient is placed erect, and pressure is applied to the external abdominal ring. In reducible hernia, on the contrary, such a procedure necessarily prevents the recurrence of the tumor. In hernia, moreover, the swelling receives a distinct impulse under coughing and other muscular exertion; while in *varicocele* the parts are perfectly passive.

In *sarcocoele* the best guides are the history of the case, the uniform hardness of the swelling, the normal state of the abdominal rings, the inability of the surgeon to affect the volume of the tumor by manipulations, and the indurated and distended condition of the scrotum. When the disease is associated with hydrocele, a part of the tumor will be likely to be translucent, soft, and fluctuating; thus strikingly contrasting with the remainder.

Solid tumors—fibrous, adipose, sebaceous, cystic, and encephaloid—developed in the scrotum, testicle, or vaginal tunic, are, in general, easily distinguished by their progress, by their form and consistence, by the nature of the local distress, and by the presence or absence of constitutional involvement.

Dr. Gurdon Buck, in 1869, met with a rare form of strangulated scrotal hernia, in a man, forty-three years of age, which was a source of great perplexity in regard to the diagnosis. The peculiarity consisted in the presence of two distinct tumors, one corresponding with the groin and the other with the testicle, with an intermediate cord of the size of a little finger, firm, and of cylindrical form. The lower swelling, very hard and of a flattened, elongated figure, was very tender and painful on pressure, the whole appearance being such as is generally witnessed in ordinary orchitis. This appearance, however, was altogether deceptive; for, upon exposing the parts, the testicle was found to be perfectly sound. The knuckle of intestine, it seems, in its descent along the cord into the scrotum, instead of distending the vaginal tunic immediately after emerging from the external inguinal ring into a sac continuous with that of the testicle, expanded it into a tubular canal of uniform size in its entire length, causing thus a condition which closely resembled an enlarged spermatic cord, such as is commonly met with in acute epididymitis. Hence the perplexity of the diagnosis. The seat of the constriction had evidently been at the junction of the tubular canal and the proper vaginal sac. The bowel was slightly gangrenous, and death ensued on the fourth day after the operation.

Treatment.—Scrotal hernia, whether reducible, irreducible, or strangulated, is treated upon the same general principles as hernia of the groin, of which, as was stated before, it is merely a continuation. A suitable truss is the proper remedy for the reducible variety, and the prospect of a permanent cure under its influence will be in proportion, all other things being equal, to the recentness and small size of the tumor. The pad is, of course, placed over the internal ring, or, in cases of long standing, just above the external, the relative position of the two apertures, under such circumstances, not being forgotten. When the hernia is irreducible, it should be supported, both day and night, with a suspensory bandage, provided with shoulder-straps, otherwise it will answer the purpose but indifferently. By means of such an apparatus, the patient will be relieved of much of his inconvenience, at the same time that the tumor will be protected from further increase. Great attention should also be paid to the bowels, which should be constantly maintained in a soluble condition. The diet should be plain and simple, easy of digestion, and comprised in the smallest possible bulk, lest the alimentary tube should suffer from

flatulence and fecal distention. All violent bodily exertion, fatiguing walks, and exercise on horseback must be avoided. The taxis, in case of strangulation, is conducted in the usual way; and in dividing the stricture, which will generally be found to be at the external ring, the knife is carried directly upwards.

A very singular case of scrotal hernia, in which the strangulation was produced by the obturator artery, in its upward course from the epigastric, has been reported by Professor John Cleland, of Galway. The vessel was stretched across the tumor, which was about the size of a hen's egg, like a tight cord, and all constriction disappeared the moment it was divided, a ligature having previously been thrown around it at two points.

Congenital Scrotal Hernia.—The formation of congenital scrotal hernia will readily be understood if it be remembered that the testicle is originally situated upon the psoas muscle, immediately below the kidney, and that, as it descends to the place which it is destined finally to occupy, it carries with it a process of the peritoneum, constituting what is called the vaginal tunic of this organ. Ordinarily, the portion of membrane lying in the inguinal canal is closed before birth, thereby cutting off all communication between the scrotum and the general abdominal cavity; but at times the reverse is the case, and then an opportunity is afforded for the protrusion of the abdominal viscera and the formation of the variety of hernia in question. Occasionally, the testicle, as it descends towards the internal ring, becomes adherent to a coil of intestine which it thus carries along with it. It would seem from the dissections of Camper, Seiler, Schreger, Paletta, Birkett, and others that the vaginal process of the testicle remains much more frequently than is generally supposed, establishing thus a remarkable predisposition to the occurrence of hernia. Paletta, indeed, asserts that the closure is seldom effected before the twentieth, twenty-fifth, or thirtieth day. Occasionally a narrow canal remains during early childhood.

Congenital scrotal hernia is of frequent occurrence, and is capable, if neglected, of acquiring a large bulk. In a case recently under my observation, in a child, only two years old, the tumor was fully as large as a foetal head, and extended two-thirds down the thigh. In general, however, it is quite small, and easily reducible; the testicle lies at the bottom of the tumor, and the vaginal tunic, which always forms the proper hernial sac, usually contains a small quantity of water. The external coverings of the tumor are the same as in scrotal hernia of the adult. The contents commonly consist of bowel alone, generally of a fold of the ileum; in some cases of both bowel and omentum; and occasionally, although very rarely, exclusively of omentum.

A reducible congenital scrotal hernia requires the same management as an ordinary inguinal one; but it will be well not to begin the treatment with the truss, inasmuch as it is generally impossible for the little patient to bear the pressure of such an instrument without severe suffering. Instead of this, the parts should be supported with a compress and roller, or, what is better, with a gum-elastic girdle, provided with a broad, elastic pad. In this way, an increase of the tumor may be pretty effectually prevented until the child has reached the age of three, four, or six months, when it will commonly be able to wear a truss, which may then advantageously replace the earlier and less perfect contrivance. Whatever apparatus be employed, great attention must be paid to cleanliness and to the prevention of undue irritation of the skin. If worn persistently, a radical cure may often be effected in a very short time, as the parts at that period of life always manifest a strong disposition to close after the descent of the testicle.

It is not often that a congenital scrotal hernia becomes irreducible, and it is still more rare to see it strangulated. Such an event, which has occasionally been witnessed within a few days after birth, is characterized by the ordinary phenomena, and may generally be promptly relieved by the taxis. If this fail, the knife must be used, but with the utmost caution, on account of the great thinness of the external covering of the rupture, and the liability of peritonitis from the division of the vaginal tunic of the testicle, which, as before stated, forms here the proper hernial sac.

Fig. 457.



infantile Scrotal Hernia.

Infantile Hernia.—A very rare form of scrotal rupture is occasionally met with, generally described under the vague name of infantile hernia, fig. 457, and regarded as a subdivision of the congenital, although it has been found several times in adults who had been entirely free from all complaints of this kind in early life. Its peculiarity consists in having the vaginal tunic of the testicle in front of the proper hernial sac, so that, if a dissection be made of the parts, the protruded viscera will be seen to be invested by three distinct serous layers, besides the ordinary external coverings. In other and more explicit terms, the communication between the vaginal tunic and the abdominal cavity is completely shut up, but this membrane, instead of merely inclosing the testicle, as in the natural state, extends high up around the spermatic cord, forming thus a sort of pouch, behind which the viscera descend, in company with a prolongation of the peritoneum, which thus constitutes, as in ordinary cases of rupture, the proper hernial sac.

FEMORAL HERNIA.

It would be well if the term crural could be altogether dispensed with in treating of hernia of the thigh, and the word femoral alone used. Such a course would materially simplify the subject, and relieve it of much of the confusion which has hitherto attended its study. Under this conviction, I shall limit myself in the remarks which I am about to offer upon this form of rupture, exclusively to the employment of the latter designation.

In femoral hernia, the abdominal viscera descend beneath Poupart's ligament, along what is called the femoral canal, the tumor, when fully developed, showing itself at the upper and inner surface of the thigh, as represented in fig. 458. In order to comprehend the precise relations of the protruded parts to the surrounding structures, it will be necessary to recall a few of the anatomical elements concerned in its formation. In the first place, then, it may be observed that the passages along

Fig. 458.



Ordinary Site and Appearance of Femoral Hernia.

Fig. 459.



Femoral Hernia. *a.* The Sac. *b.* The Femoral Vein. *c.* The Artery. *d.* The Abdominal Ring. *e.* Section of the Psoas and Iliac Muscles. *f.* The Acetabulum.

which the bowel courses, bear a very strong resemblance to those which are concerned in the formation of an inguinal hernia by the oblique descent, consisting, like them, of a canal and two openings, as seen in fig. 459, one denominated the internal ring, and the other the external. To render the similitude more pointed, I shall designate the openings as the femoral rings, and the intervening track as the femoral canal; in the same manner as there are two inguinal rings and an inguinal canal.

The internal femoral ring is somewhat of a triangular figure, being bounded anteriorly by Poupart's ligament, behind by the pubic bone, externally by the femoral vein, and on the inside by Gimbernat's ligament, or the third attachment of Poupart's. This opening is considerably larger in the female than in the male, and this is one, if not the principal, reason why this variety of rupture is so much more fre-

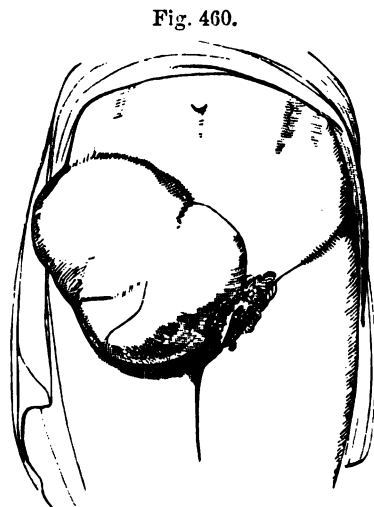
quent in the former than in the latter. It is naturally closed by a lymphatic gland and a small quantity of cellulo-fatty matter, which thus generally offer not a little resistance to the descent of the abdominal viscera. The external femoral ring, usually called the saphenous opening, because it is here that the saphenous vein empties into the great femoral, is of an ovoidal shape, very spacious, and bounded by the crescentic edge which is formed here by the femoral aponeurosis. It is occupied by a number of lymphatic glands, as well as by a large mass of dense, cellulo-adipose substance, forming what is termed the cribriform fascia, a structure playing an important part in the anatomy of femoral hernia. The canal between the two openings now described is very short, especially in front, its wall here being formed solely by the upper lunated border of the external ring, known as Hey's ligament. The posterior wall, on the contrary, is much longer, and is represented by the pubic portion of the femoral aponeurosis. Thus constituted, the passage is lined by a prolongation of the transverse fascia in front and of the iliac behind, together with a thin layer of cellulo-adipose tissue, which, lying immediately beneath the former fascia, is continuous above with the cellulo-fatty matter which aids in filling up the internal ring, and below with the cribriform fascia. This substance, it may now be remarked, forms what is called the proper fascia of femoral hernia.

The abdominal viscera, passing down the thigh, through the openings here described, clothe themselves with a portion of peritoneum, which thus, as in the other varieties of the complaint, constitutes the proper hernial sac. If, therefore, a dissection be made of the coverings of the tumor, extending from without inwards, they will be found to present themselves in the following order:—skin, superficial fascia, cribriform fascia, the funnel-shaped process of the transverse fascia, the proper fascia, and, lastly, the peritoneum. The position of the epigastric artery and the spermatic cord is deserving of particular notice in relation to this variety of rupture. The former always lies on the outside of the tumor, close to its neck, while the latter lies above and internally. The obturator artery, when given off by a trunk common to it and the epigastric, as it is supposed to be in every fourth case, arranges itself along the anterior and upper part of the tumor.

The contents of a femoral hernia usually consist exclusively of small intestine, generally a portion of the ileum, especially in cases of recent standing; but under opposite circumstances, and, in particular, when the tumor is bulky, both bowel and

omentum frequently enter into its composition. Instances in which omentum alone protrudes are by no means uncommon; and I have a preparation, taken from a lady upwards of seventy years of age, who had long labored under double femoral rupture, in which the contents are exclusively of this character. Examples are met with, although rarely, in which the tumor is composed of the ovary and Fallopian tube, of the uterus, or of the uterus, Fallopian tube, ovary, and vagina. A case has been recorded in which the urinary bladder was the part protruded. Femoral hernia occasionally coexists with inguinal.

The tumor in femoral hernia is always small compared with that of inguinal hernia, seldom exceeding the size of an almond, and occasionally hardly attaining that of a nutmeg. Sometimes, however, its bulk is quite extraordinary, equalling that of a fist, or even that of a foetal head, as in fig. 460. In the latter case, the tumor is commonly of a globular shape, whereas, ordinarily, it is of an elongated ovoidal figure, longer



Femoral Hernia, of very Large Size.

in the transverse diameter than in the vertical. The hernia may be complete or incomplete, as in the inguinal varieties of the complaint. In the former case, the viscera escape at the external ring, and form a tumor which lies on the upper and inner surface of the thigh, immediately below Poupart's ligament, and a little external to the spine of the pubes. In order to reach this point, the parts are obliged, upon arriving at the external ring, to change their direction, passing upwards towards

the groin instead of downwards towards the knee, and in doing this the two portions are doubled upon each other. The reason of this change of direction, a knowledge of which is so important in relation to the proper employment of the taxis, is the manner in which the saphenous vein enters the femoral, and the peculiar connection of the cellular tissue at the lower margin of the external ring, with the femoral aponeurosis. The barrier thus formed, however, is sometimes broken down, and then the hernia not only descends along the thigh, but often acquires an extraordinary bulk from the restraint being thus taken off. In the incomplete form of the disorder, the tumor is always very small; and it is on this account that the true nature of the case is very liable to be overlooked, the intercepted portion of bowel occasionally not exceeding one-third, one-half, or two-thirds of the diameter of the tube. It is, in fact, a most dangerous form of hernia, similar, in every respect, to concealed, interstitial, or interparietal hernia of the groin, described on a previous page. In the case from which the sketch, fig. 461, was taken, the protruded part was hardly the size of a pea-nut without its shell.

Femoral hernia, as already stated, is much more frequent in women than in men. Of 6210 cases reported by the London Truss Society, 5511 were females, and 699 were males, or nearly in the ratio of 8 to 1. Of 407 cases analyzed by Frickhöffer, 352 occurred in females and only 55 in males. The complaint is occasionally noticed in children, but very seldom before the twelfth year.

Diagnosis.—Femoral hernia is liable to be mistaken for other affections, from which it is of the greatest consequence that it should be distinguished. Of these the most important are inguinal hernia, psoas abscess, varix of the saphenous vein, and enlargement of the lymphatic glands.

In regard to the distinction between femoral and *inguinal hernia*, little difficulty can arise if it be remembered that, in the former, the neck of the tumor is below Poupart's ligament, while in the latter it is above. A good plan, therefore, in cases of doubt, is to trace the course of this ligament along its inner half with the finger, when, if it be found to be overlapped by the swelling, it may be assumed that the hernia is inguinal, it being well known that a femoral hernia rarely, if ever, ascends so high up. Besides, important information may be gained by a careful examination of the inguinal and femoral rings, the former of which, in particular, will always readily admit the tip of the finger when it is not occupied by the abdominal viscera. The size and shape of the tumor are not to be disregarded. In femoral hernia it is small and transversely elongated; in inguinal, on the contrary, it is comparatively large, and of an irregular, hemispherical shape. In the former, the tumor is fixed, and, when strangulated, soon becomes very tender; in the latter, it is movable, and does not suffer so early, nor are the constitutional symptoms usually so urgent.

A consideration of the sex is not to be disregarded in the investigation. Femoral hernia, as before stated, is much more common in women than in men. Age also is important. Inguinal rupture is liable to occur at any period of life; femoral, on the contrary, is seldom seen until after the fortieth year, and is by far most frequent in elderly subjects.

Psoas abscess occasionally points beneath Poupart's ligament, forming a tumor, of variable size and shape, at the upper and inner part of the thigh, which may be mistaken for femoral hernia. The error will be most likely to occur when the swelling is small and recent; even then, however, a little care will generally suffice to establish the diagnosis. The best guides are the history of the case, the flexed condition of the thigh, with a certain degree of lameness, and the fact that the swelling always readily disappears under pressure during recumbency.

Varix of the *saphenous vein* at its entrance into the femoral, or of both vessels at this point, is sometimes met with, and has occasionally been treated as a femoral rupture. Such an error implies the most culpable carelessness, for it could certainly not be committed by any one who has the slightest tact or experience in examining

Fig. 461.



Femoral Hernia, Strangulated by a very Small Part of the Bowel being caught in the Femoral ring.

patients. The diagnosis will always be easy when it is recollected that a varix is much softer than a femoral hernia; that it has a peculiar knotty feel; that it always coexists with varicose enlargement of the saphenous vein below; and that, after having been effaced by manipulation, it speedily reappears under pressure applied to the femoral vein just above the external ring, when the patient stands up, no such effect following if the tumor be hernial.

The *lymphatic glands*, at the upper and inner part of the thigh, are liable to enlargement, both acute and chronic, and numerous instances have occurred of errors of diagnosis between this disease and femoral hernia, a rupture having been laid open for a supposed abscess, and an inflamed gland treated as a rupture. It is, perhaps, not always easy to discriminate between these two affections; but it is hardly possible to conceive of a case where a careful examination of the part and a proper inquiry into the previous symptoms would not promptly dispel all doubt in relation to its real character. When symptoms of strangulation exist along with a tumor of a suspicious nature, and one which does not promptly yield to antiphlogistic measures, the rule is to operate, both in this and in other varieties of hernia. What complicates these cases occasionally, and embarrasses the diagnosis, is the coexistence of glandular enlargement and femoral hernia, the latter of which is then apt to be very small and concealed by the former.

Treatment.—Reducible femoral hernia must be treated with a well-adjusted truss, constructed upon the same principles as that used for inguinal hernia. It should rest over the hips midway between the crest of the ilium and the great trochanter, and should be provided with a small, slender block, very convex on the surface, and fastened to its spring nearly at a right angle. The object should be to concentrate the pressure as much as possible, which cannot be done when the pad is broad and flat, on account of the constant motion of the pectineal muscle. Care must be taken not to permit the block to exert any injurious compression upon the femoral vein, which, by embarrassing the return of the blood, might thus occasion serious mischief in the limb below, as anasarca, and even active inflammation. The precise spot where the pressure is to be made is just below Poupart's ligament, and a little external to the spine of the pubes, directly in the line of the femoral canal and the upper portion of the external ring, it being impossible, by any contrivance yet devised, to concentrate the pressure upon the internal ring. It is for this reason, in part, that a femoral hernia is so seldom radically relieved, the other causes of failure being found in the peculiar nature of the boundaries of the internal ring, these being partly osseous and partly ligamentous, and, therefore, in great measure, insusceptible of adhesive action. A truss, then, in this variety of rupture, should be worn rather as a retentive apparatus than as one designed to bring about a permanent cure. Owing to the circumstance, however, just alluded to, it is questionable whether a small portion of the hernia does not generally remain above the block of the instrument, within the mouth of the internal ring.

The *irreducible* hernia of the thigh is best supported by a truss with a hollow pad, so arranged as to receive and accommodate the protruded mass, and thus protect it from further increase, as well as from external injury. A piece of tin, silver, or gutta-percha, adapted to the shape of the tumor, well padded, and provided with a narrow margin, would answer a good purpose in such a case. The neck of the pad, or the part which intervenes between the pad and the spring of the truss, might be composed of some elastic substance, to enable these two portions to move upon each other in the various attitudes of the thigh and body. A proper support of this form of rupture is particularly important, since, if it be permitted to increase, it may acquire a large bulk, and thus greatly interfere with the patient's occupation, not to mention other inconvenience, and the risk of strangulation.

A case of partially irreducible femoral hernia, radically cured by operation, was recently communicated to me by Dr. A. Ball, of Zanesville, Ohio. The patient, a woman, forty-eight years of age, had an old rupture, the size of a goose's egg, of an elongated, ovoidal shape, in the centre of which was a hard substance, which, upon removal, was found to be the right ovary, attached by a short pedicle, and surrounded by at least six ounces of limpid fluid. The sac containing the bowel seemed to be separate from that in which the ovary was situated; it was dissected up as far as its attachment to the femoral ring, and then carefully cut off, a silk ligature having previously been thrown around its neck. The wound was closed by suture, and a rapid recovery followed without any untoward symptoms.

For the relief of *strangulated* femoral hernia the taxis is employed; early, if possible, to obviate the necessity of an operation, and gently, in order that no harm may befall the compressed and entangled structures. It is of the greatest practical moment to remember that the symptoms here are always, other things being equal, much more urgent than in strangulated inguinal rupture, and that mortification occasionally takes place within less than twenty-four hours after the occurrence of the accident. Time, then, is a matter of immense consequence in nearly all cases of this description. With a view of affording the taxis the best chance of success, particular attention should be paid to the position of the patient, the head, shoulders, and pelvis being thoroughly elevated, the legs flexed upon the thighs, and the thighs upon the pelvis, and both limbs, but especially the affected one, strongly rotated inwards. The object of the latter procedure is to relax, as completely as possible, the lunated margin of the external ring, which, particularly in the more perfectly developed forms of the affection, always exerts a very powerful constricting influence. For want of this precaution, the practitioner, unacquainted with the anatomy of this region, often signally fails in accomplishing his object, whereas, if a proper course were pursued, he would, perhaps, experience little, if any difficulty. The effect which this structure exerts upon the reduction of the protruded parts is well exemplified upon the dead subject, when the limb is alternately everted and inverted after a coil of intestine has been pushed through the femoral canal and brought out at the external ring. It will then be seen that the former movement invariably pinches and compresses the bowel, while the latter relaxes it, and thus places it in a better condition for prompt and safe replacement.

The important rule now described being complied with, and the patient being fully under the influence of anæsthesia, the next step is to draw the tumor downwards and slightly inwards, to efface the elbow which it forms with the femoral canal, and to bring it opposite the external ring. The parts are now pushed directly backwards, so as to get them fairly out of the reach of the lunated edge of the ring, when, the pressure being next made in an upward direction, the reduction is, in general, easily accomplished. It is seldom that the bowel ascends with a gurgling noise, unless the protrusion is large, when the sound may be as distinct as in ordinary inguinal hernia.

The length of time during which the taxis should be persisted in must, of course, be influenced by the circumstances of each particular case; but it may be stated, as a general rule, that it should be considerably less than in hernia of the groin: the efforts, too, should, if possible, be conducted with more gentleness, and no auxiliary measures, save anæsthesia and bloodletting, should ordinarily be called into requisition. If the symptoms are not urgent, or denotive of inflammation of the part and peritoneum, trial may be made, after the first failure of the taxis, of anodynes and topical applications, either cold or warm, care being taken, in the meanwhile, to maintain the body and limbs in a position favorable to spontaneous reduction. If, after a certain period, the protruded parts do not return, or if, after a second effort, the taxis again fail, the symptoms gradually, but steadily, advancing, no time should be lost in having recourse to the knife. To wait longer might endanger both the part and system.

An operation being determined upon, the patient is placed in the same position as in the operation for inguinal hernia, when an incision is made over the upper portion of the tumor, parallel with Poupart's ligament, and intersected by another carried down perpendicularly towards its base; or, instead of this, a T-shaped incision is made; or, if the hernia is very diminutive, a single vertical cut may suffice. The skin and cellular tissue being thus divided, the greatest caution will be required in executing the remaining steps of the operation. Layer after layer is now elevated, and divided upon the grooved director, any lymphatic glands that may be in the way of the knife being pushed aside beyond the reach of harm. The cribriform fascia is often of considerable thickness, especially in corpulent subjects, and, along with the glands involved in its substance, forms a confused mass, difficult to unravel. This having been penetrated, the next structure that presents itself is the anterior layer of the sheath of the femoral vessels, below which, and in immediate contact with the hernial sac, is a thin stratum of cellular tissue, intermixed with a few granules of fat. Dividing this, if possible, with increased caution, the operator next searches for the seat of the stricture, which will usually be found at the lunated edge of the external ring, especially at its outer and upper part, at Gimbernat's liga-

ment, or at Poupart's ligament. This examination may be made with the grooved director, or, what is preferable, with the finger, which is followed immediately with the probe-pointed bistoury, or hernia-knife, with which the resisting structure is slightly notched, the smallest incision being generally sufficient for the purpose. The protruded parts are next gently compressed with a view of unloading the bowel of its contents, and the omentum of its blood, after which they are carefully returned into the abdomen, the sac being left intact. But it may happen that the stricture is seated within the sac, particularly if the hernia is large and old, and then the sac must, of course, be laid open, its division being effected in the same manner as in inguinal hernia, only more cautiously, because the sac is usually drawn very tightly over its contents, and seldom contains more than a few drops of serum. Finally, it may be stated that in femoral hernia, consequent upon wounds, the external coverings are sometimes so extremely thin as to permit the peristaltic motions of the bowel to be seen through them.

In dividing the stricture in femoral hernia, it is of the greatest consequence to remember the relations which the tumor bears to the femoral vein, the epigastric and obturator arteries, and the spermatic cord, lest these important structures should be interfered with, and a copious, if not fatal, hemorrhage be the result. To accomplish this object, the safest rule is to carry the knife upwards with a very slight inclination inwards, and to keep it as much as possible behind Poupart's ligament. If the instrument were to be directed outwards, the femoral vein might be punctured, as has happened in more than one instance; if inwards, the spermatic cord might be endangered; and if too far forwards, the obturator artery, should it lie in front of the tumor, as it does when it is given off by the epigastric, might be wounded. Seeing how closely the tumor is embraced by these important structures, the surgeon should be most cautious in his movements, taking care, above all things, to make as little use of the knife as possible in dividing the stricture. It would be well, indeed, if the edge of the instrument were quite blunt, and if the necessary division were effected with a kind of sawing motion, as such a procedure would afford the vessels in question a better opportunity of escaping injury. Should hemorrhage, however, arise, despite the utmost precaution, it must at once be arrested by the ligature; or, when this is impracticable, on account of the inaccessible situation of the vessel, by means of pressure, either with the finger of a relay of assistants, or an appropriate compress and bandage, retained until all danger of bleeding is over.

The after-treatment is the same as in inguinal hernia; and similar precautions are necessary in regard to the use of the truss when the patient begins to walk about.

Anomalous Forms of Femoral Hernia.—In addition to the varieties of femoral rupture above described, there are several others, which, although extremely rare, deserve brief notice. These anomalies, for so they should be considered, refer chiefly to the passage of the protruded parts and the relation which they bear to the neighboring vessels, and to the shape, size, and contents of the tumor.

Hesselbach mentions an instance in which the sac of the rupture had descended behind Poupart's ligament, between the femoral vessels and the anterior superior spinous process of the ilium. It lay under cover of the iliac portion of the femoral aponeurosis, its neck being crossed by the internal circumflex iliac artery. Mr. Stanley met with one in which the sac, about the size of a walnut, lay directly in front of the vessels; and in another case, mentioned by the same author, it passed out of the abdomen external to these vessels, but close to them. A similar example has been recorded by Mr. Partridge.

Cloquet also describes a case in which the parts had descended in front of the vessels of the thigh. The same anatomist saw an instance in which the tumor had passed through an opening in the posterior part of the sheath, so that it lay immediately upon the pectineal muscle, and, consequently, behind the artery and vein, separated from them only by the deep-seated portion of the fascia. Similar examples have been observed by Callisen, Le Gendre, Richet, Adams, and others.

There is a variety of femoral hernia, first noticed by Laugier, in which the bowel passes through the fibres of Gimbernat's ligament. It lies, of course, internal to, and at a considerable distance from, the great vessels.

In nearly all of these anomalous cases the epigastric artery, or this vessel and the obturator, is intimately connected with the sac of the hernia, either crossing it

in front, or running closely along its inner surface. Hence, if the point of the knife be used in the division of the stricture or the deep-seated coverings of the tumor, a troublesome, if not a fatal, hemorrhage will almost be inevitable.

The surface of the femoral hernia, instead of being smooth and uniform, as it generally is, is sometimes remarkably constricted, having a kind of hour-glass appearance, caused either by the passage of a vessel of considerable size, or by the unequal compression of the overlying fascia.

Occasionally, again, the sac is multilocular, or divided into several compartments. In a case mentioned by Monro there were not less than four such cavities, of which three communicated with each other.

The parts are sometimes included in a double sac. Chevalier met with two instances in which a sac containing bowel lay within another sac, in such a manner as to fill up completely the aperture, to which it was firmly adherent. A similar case has been reported by Dupuytren.

Ordinarily the femoral rupture is very diminutive, its volume not exceeding that of a small almond or a pigeon's egg. Now and then, however, an instance occurs in which the tumor descends half way down the thigh, or fills up almost completely the space between the anterior superior spinous process of the ilium and the pubic symphysis. A unique case of a large femoral hernia, the walls of which were so thin as to permit the peristaltic motion of the bowel to be perceived, has been recorded by Thompson.

Although the femoral hernia is generally composed entirely of intestine, an instance occasionally occurs where the contents are exclusively omental. In a case of double femoral rupture in an old lady, whose body I examined after death, each tumor contained merely a process of omentum, one of which had become much enlarged and indurated from its protracted imprisonment.

UMBILICAL HERNIA.

In umbilical hernia the abdominal viscera are protruded at the umbilical ring, or what is vulgarly called the navel. The complaint is much more frequent in women than in men. Thus, of 2775 cases of umbilical hernia reported by the London Truss Society, 2111 occurred in the female, and only 664 in the male, or in the proportion of about $3\frac{1}{4}$ to 1. The affection displays some variety according as it shows itself in the fœtus, in the infant, and in the adult.

In the Fœtus.—Umbilical hernia of the fœtus is always dependent upon defective development of the walls of the abdomen, and is frequently associated with malformation of other parts of the body, as harelip, bifid spine, clubfoot, or exstrophy of the bladder. In one case under my care, the infant had hypospadias and an additional finger on each hand.

The contents of an umbilical hernia usually consist of a coil of the small intestine, or of this portion of the bowel and of the colon, sometimes of the liver, occasionally of the spleen, and now and then, but very rarely, of the stomach. The affection has been noticed at a very early period of fœtal existence, although it is most common during the latter stages of pregnancy. The tumor varies in volume, according to the extent of the deficiency in the parietes of the abdomen, from that of a thimble to that of a fist. It has a proper hernial sac, but no cutaneous covering, its external investment consisting of the transparent envelop of the umbilical cord, united to the peritoneum by a thin layer of cellular tissue. The umbilical vessels are sometimes separated by the protruded viscera, and the cord is generally situated at the inferior margin of the tumor, or a little to one side of it.

When the umbilical tumor is large, death usually takes place within a few days after birth, from the effects apparently of peritoneal irritation. If the child survives, an attempt may be made to bring about a permanent cure by transfixing the edges of the umbilical ring with several delicate pins, and winding around each, in an elliptical form, a well-waxed ligature, as in the common harelip suture. In performing the operation, care is taken not to interfere in the slightest degree with the peritoneum; the pins should be retained the better part of a week, and the abdomen should be thoroughly supported in the interval, as well as for some time after, by broad strips of adhesive plaster, or a gum-elastic bandage.

In the Child.—Umbilical hernia in the child generally comes on within the first

two or three months after birth, and cases occur where it is congenital, or where it appears soon after the first severe paroxysm of crying. Whatever may be the period of its evolution, the immediate cause of the disease is a succession of violent muscular efforts, by which the abdominal viscera are forcibly impelled against the umbilical aperture, before it has had time to become completely obliterated. The tumor, which rarely exceeds a common marble in bulk, is either hemispherical or conical, soft and gaseous in its consistence, and sensibly impressed by crying, laughing, coughing, or sneezing; retiring under pressure, and reappearing immediately when the pressure is removed. If, after the reduction has been effected, the finger be inserted into the opening, it will be found to be of a circular shape, with sharp, well-defined edges. The coverings of the tumor are the skin, cellular tissue, and peritoneum, its ordinary contents being small intestine; very rarely omentum, or omentum and intestine. In a case related by Cabrolus, the hernia consisted solely of the bladder, the child, a female, having been born with obstruction of the urethra. The organ soon gave way externally, so as to admit of the free discharge of the urine in this direction. At the age of eighteen, however, the natural channel was restored by operation, the fistule closed, and the hernia gradually disappeared.

An umbilical hernia in the child must be treated upon the same general principles as a similar rupture in the adult. If the disorder receives early attention, a radical cure may often be effected in a very short time, as there is always, at this period, a great tendency to contraction of the umbilical ring. Sometimes, indeed, the hernia disappears spontaneously, even after it has made considerable progress, especially when the general health is good, when there is not much obesity, and, above all, when care is taken to avoid the exciting causes of the complaint. Such a fortunate event, however, is very uncommon; hence, the best plan always is not to wait for it, but to treat the case at once with a retentive apparatus, adapted to the age and comfort of the little sufferer. The contrivance from which most benefit is to be expected is a leather, wooden, ivory, gutta-percha, or metallic pad, of a circular shape, perfectly flat, large enough to overlap the edges of the ring, and confined by a few broad strips of adhesive plaster, carried completely around the body. Over this, a broad gum-elastic band should be worn, in order to give due support to the whole abdomen. If the child has attained the age of two or three years, a proper truss should be used, such as that worn in this variety of hernia in the adult. If, under this treatment, a radical cure be not effected, the edges of the ring should be transfixed by a stout silver needle, fastened by a ligature, and retained until firm union is obtained. The subcutaneous wire suture might also be tried. No danger would be likely to result from either procedure. If strangulation should occur, and an operation be demanded, opening of the sac must be carefully avoided, lest fatal peritonitis should be provoked.

In the Adult.—In the umbilical hernia in the adult the tumor is usually globular, or pyriform, and, from not being larger originally than the end of the finger, it may, as it increases in age, acquire an enormous volume, extending, perhaps, as low down as the pubes. In corpulent persons it often manifests a disposition to insinuate itself beneath the skin, within the adipose matter, and the consequence is that it sometimes forms hardly any perceptible enlargement, as it does when the subject is emaciated. A hernia in such a state is peculiarly dangerous if it happen to become strangulated, from its liability to be overlooked, and, therefore, mismanaged. An instance of a fatal mistake of this kind occurred, some years ago, in the hands of a medical friend, a man of great intelligence, who never suspected the true nature of the disease until it was revealed by dissection after death. The patient was a married woman, whose abdomen was loaded with an enormous quantity of fat, beneath which a large, strangulated umbilical hernia existed.

An umbilical hernia in the adult generally contains omentum, or omentum and a portion of the colon; sometimes small intestine, but very rarely alone. The stomach and other viscera are occasionally included in it. Many years ago I dissected the body of a woman, the mother of three children, in whom the hernia was composed exclusively of the gravid uterus, near the full period of gestation. The centre of the tumor bore distinct evidence of the remains of the umbilicus. A similar case has been described by Murray. An instance of a double umbilical hernia occasionally occurs. The coverings of the tumor consist of the skin, superficial fascia, and peritoneum, the latter of which, especially in cases of long standing,

is sometimes very thin, or thin at one point and thickened at another. The umbilical ring is generally towards the upper part of the tumor.

The most common causes of this form of rupture are laborious parturition, pregnancy, and habitual straining at stool. Females are much more subject to it than males, and fat persons than lean; it is rarely met with before the age of twenty-five or thirty, or until after the abdomen has become enlarged and pendulous from incessant distention of its walls. Constipation of the bowels, flatulence, colicky pains, nausea, and other evidence of gastro-intestinal disorder are common attendants upon this variety of hernia. An instance in which strangulation of the small bowel occurred in an old hernia of this kind, in consequence of an opening formed in the umbilicus by ulceration, has been reported by Dr. T. L. Ogier, of Charleston, South Carolina.

The diagnosis of umbilical hernia is generally sufficiently easy. When any difficulty arises it is usually due to the existence of a fatty tumor, an instance of which occasionally occurs in the linea alba, where, especially if it is small, it may be mistaken for an omental rupture. Scarpa very candidly confesses that he once committed an error of this kind. A woman was seized with colic and nausea, accompanied with constipation and painful tympanites. A tumor, the size of a large nut, existed just below the umbilicus, on the left side of the middle line. Convinced that it was a strangulated hernia, an operation was performed, when it was ascertained that the tumor was merely a small mass of hard fat.

The means best calculated for the retention of a small umbilical rupture in the adult is a truss with a wooden block, at least two inches in diameter, slightly convex upon its abdominal surface, and secured to an elastic spring, long enough to encircle the body. The ends of the spring should be fastened behind to a broad, oblong pad, six inches in length, and arched transversely, to adapt it the more accurately to the spine. When there is much obesity, or great volume of tumor, the block should be proportionately larger, and the operation of the instrument should be aided by a gum-elastic supporter, which, by taking off the weight of the abdominal viscera, will thus serve to diffuse and equalize their pressure against the abdominal parietes. No truss that does not combine these qualities can be considered, under such circumstances, as of much value; for, although a radical cure can seldom be effected in any case, there is hardly a tumor, however large, inconvenient, or painful, that may not be materially relieved by these means. As to the blocks and pads with a central prominence, until lately so much used in this country, it would be difficult to conceive how they could produce any other than an injurious effect, as their action must inevitably be to separate still farther the edges of the umbilical ring into which the knob projects.

One of the peculiarities of the umbilical hernia in the adult is that, if neglected or mismanaged, it soon becomes irreducible, either from the enlargement of its contents, or from their adhesion to each other and to the inner surface of the sac. Hence, every possible endeavor should be used to prevent this occurrence, or, if this be impracticable, to restrict it within the smallest possible limits by suitable antiphlogistic and retentive means. The existence of tenderness and pain in the tumor, constipation of the bowels, nausea, and general uneasiness in the abdomen, should be attentively watched, and regarded with suspicion. Should the symptoms increase instead of diminishing, blood should be abstracted by the lancet and by leeches, the rectum stimulated by injections, and the belly well fomented with hot water and laudanum. To aid in the removal of plastic matter, small doses of mercury may be used for some time after, and sorbefacients applied to the tumor. If, notwithstanding these precautions, the hernia remains irreducible, or if it was so before the surgeon was consulted, timely measures must be employed for the prevention of its further increase, as well as for its protection against external injury. The most efficient and convenient apparatus for this purpose is a hollow truss, cup-shaped, well padded, and retained in place by a scapulary, or the addition of a gum-elastic supporter. To obviate griping, flatulence, and dyspepsia, a concentrated, easily digestible diet and a soluble state of the bowels should be enjoined.

If strangulation ensues, no time should be lost in employing the taxis, the patient being anesthetized, and placed pretty much in the same position as under similar circumstances in the other varieties of hernia. If the tumor is at all bulky, its contents, after having been drawn away from the umbilical ring, must be pressed

directly upwards, or upwards and backwards, in a direction opposite to that of the protrusion, it being remembered that in all cases of this kind the tendency of the parts is to descend toward the pubes. Should the taxis fail, and the symptoms not be urgent, the effects of a full anodyne and of cold or warm applications may be tried, and often with a prospect of success. When it is remembered how disastrous are most of the operations that are performed for the relief of strangulated umbilical hernia, it is hardly possible to lay too much stress upon the protracted and judicious employment of the taxis. There is a period, of course, when we must desist, or when further efforts of the kind would be improper, but it is not always easy to specify it, and much must, therefore, be left, in every instance, to the judgment of the practitioner.

In performing the operation, an inverted **J**-shaped incision will generally be proper, the vertical limb being carried nearly an inch above the upper extremity of the tumor, directly in the course of the *linea alba*. Bearing in mind the thinness of the external coverings, particularly in recent cases, the knife is passed, upon a grooved director, successively through the skin and cellulo-fatty matter, down to the hernial sac, which is, if possible, left intact, experience having shown that its division is fraught with the greatest danger, from its liability to be followed by fatal peritonitis. Seeking now for the seat of the stricture, which will usually be found to be at the superior margin of the ring, the knife is conducted upwards upon the finger, and the resisting structure divided to the requisite extent. The protruded parts, being drawn somewhat downwards, to liberate them from their confinement, are next gently replaced into the abdomen, first bowel and then omentum, in the usual manner. Should the constriction, however, be ascertained to be within the sac, then the sac must be opened, care being taken, for the reason already mentioned, to make the incision as small as possible. When the hernia is irreducible, the protruded structures are left, after the division of the stricture, in their extra-abdominal situation.

In the case of Dr. Ogier, above referred to, where the bowel protruded through an opening at the umbilicus, caused by ulcerative action, the edges of the orifice were united by the quilled suture, followed by a complete cure.

VENTRAL, PELVIC, AND DIAPHRAGMATIC HERNIA.

Hernia may occur at other points than those where the natural openings of the abdomen exist, the names by which it is designated having reference to the particular situation of the protruded viscera, as ventral, lumbar, obturator, and ischiatic.

a. Ventral hernia is so called from the fact that it involves the parietes of the belly, which are rendered defective in consequence of a wound, or the accidental separation of some of the muscular and tendinous fibres. It may occur in any part of the walls of the abdomen, but is most common in the middle line, above the umbilicus and in the inferior half of the semilunar line. The tumor, although generally diminutive, is capable of acquiring a large bulk, and has seldom more than three coverings, namely, the skin, superficial fascia, and proper sac. The symptoms and treatment involve nothing peculiar; nor does the operation when strangulation takes place, except that special care should be taken not to injure the epigastric artery, as might happen if the stricture were divided in any other direction than the perpendicular. The sac ought also generally to be left intact, for fear of violent peritonitis.

Pipelet, in the *Memoirs of the French Academy of Surgery*, has described a variety of ventral hernia under the name of *epigastric*, as the protrusion occurs in the region of the stomach, although no case seems to have ever been observed in which this organ was entirely included in the tumor. The rupture is generally situated a little to the left of the middle line, in a fissure between the straight muscles, and varies in size from an ordinary marble up to that of an orange. Its chief interest arises from the fact that it commonly causes considerable gastric disturbance, as pain, flatulence, and nausea. Its contents nearly always consist of a portion of omentum, or of omentum and of the arch of the colon.

b. Lumbar hernia, a comparatively infrequent occurrence, is situated, as the name implies, in the loins, between the crest of the ilium and the last rib. Coexisting

occasionally with other forms of rupture, it is generally caused by penetrating wounds, as sabre and gunshot, of the walls of the abdomen, by which the muscles are left in a weakened condition, incapable of resisting the pressure of the diaphragm, liver, and other viscera. Baron Larrey, in 1869, adduced the particulars of twenty-five cases, for the most part the effects of gunshot wounds. The affection may arise spontaneously; and an instance has been recorded by Dr. Q. C. Smith, in which it was congenital. Lumbar hernia is rarely strangulated, or the seat of serious accidents. The symptoms, diagnosis, and treatment are similar to those of ordinary rupture. The best apparatus is a gum-elastic belt, provided with buckles and thigh-straps.

c. In *obturator hernia*, the viscera follow the course of the obturator vessels, forming a tumor at the upper and inner part of the thigh under cover of the pectineal and adductor muscles, generally so small as not to be cognizable by the finger, much less by the sight. It usually consists of a portion of small bowel; is supposed to be more common in females than in males; and, owing to its deep situation, is rarely detected during life. A few cases of double obturator hernia have been observed; and in one reported by Dr. Chiene, three tumors of this kind existed, one on the left side containing a portion of strangulated ileum, and two on the right side, one of the latter being occupied by the outer half of the right Fallopian tube.

When such a rupture becomes strangulated, reduction might possibly be effected by thoroughly relaxing the muscles of the thigh, and pushing the finger directly upwards in the course of the obturator foramen. If the taxis should fail, an operation might be required, but it would be difficult of execution, and not without danger, on account of the close proximity of the femoral vessels to the line of incision. A modification of the ordinary femoral truss might answer for the retention of such a hernia when it forms a distinct external tumor.

d. The *ischiatric hernia*, which protrudes at the ischiatic notch, is extremely rare, and has probably never been recognized in the living subject. In most of the cases in which it was dissected after death, it contained small bowel; in one, the ovary was protruded, and in another, related by Haller, it was formed principally by the rectum.

e. *Perineal hernia* descends by the side of the rectum and anus, or immediately in front of these parts, its contents generally consisting either of the small intestine or of the urinary bladder. The protruded structures do not always appear externally in the perineal region, but occasionally they form a tumor of the volume of a pullet's egg. In a case which came under my observation, some years ago, in a middle-aged lady, the mother of six children, the tumor, which lay between the vagina and rectum, and was of a very soft consistence, was about the size of an ordinary marble, and easily reducible by the slightest pressure. The most remarkable feature about it was its transparency, which was so great that the bowel could almost be seen through it. It had existed for many years, but had not been productive of any physical inconvenience.

f. Under the term *hedrocele*, Dr. Uhde, of Brunswick, has described a very rare form of hernia in which the intestine protrudes at the anus. The tumor, which is accompanied by a distinct serous sac, is of a spheroidal or cylindrical shape, of a red color, and marked upon its surface by mucous follicles and enlarged veins. In its recent state, it is soft and spongy, and easily reducible; but if allowed to remain down for any length of time, it is liable to become œdematous, very tense and resisting to the touch, especially in the part where it lies in the recto-vesical or recto-uterine pouch, and may even undergo strangulation, followed by gangrene, and, if the patient survive, by fecal abscess and artificial anus. The affection, at first sight, bears a close resemblance to prolapse of the anus, but is readily distinguished from it by the usual phenomena. The prognosis is unfavorable, from the irreducibility of the tumor and its liability to strangulation. The only thing to be done is to support the parts with a soft pad attached to a bandage.

g. *Labial hernia* is a very rare form of this complaint, in which the parts descend between the vagina and the branch of the ischium. The tumor, which is soft and elastic, varies in size from a small marble to a pullet's egg, readily recedes under pressure, and is usually situated in the inferior half of the great lip, beneath the mucous membrane. It is nearly always composed of a portion of bladder, the cases

in which it contains intestine being extremely rare. In a woman examined by Mr. A. Burns, a hernia, occupied by the bladder, existed in each labium. The affection is distinguished from inguinal hernia by the natural state of the external ring, and by the fact that the tumor may be traced with the finger into the pelvic cavity. When the rupture becomes troublesome, it may be restrained by a pessary, or a gum-elastic bandage, the constant use of which has occasionally produced a radical cure. Strangulation is, in general, easily relieved by steady and persistent pressure; this failing, the sac is exposed, and the stricture divided in the direction of the vagina.

h. Vaginal hernia is merely a variety of the labial; it presents itself under two varieties of form, the anterior and posterior, the first usually containing bladder, and the other intestine. It varies in size in different cases, being sometimes not larger than a thimble, while, at other times, it is so voluminous as to block up the whole vagina; it is of an irregular, globular shape, elastic, free from pain, influenced by coughing, and easily reduced by pressure. The treatment consists of rest in the recumbent posture, astringent injections, a stem pessary, and an abdominal supporter, aided, when the tumor is cystic, by the occasional use of the catheter.

i. Occasionally the abdominal viscera project into the chest, thereby constituting *diaphragmatic hernia*. The left side is more frequently involved than the right, and the protruding parts usually consist of the stomach, colon, omentum, or small intestine, the order of frequency being as here stated. The liver, spleen, and even the pancreas sometimes enter into the composition of the hernia. The affection may be produced by external violence, as a fall, blow, or wound, or by severe straining in vomiting; in the majority of instances, it is the result of congenital malconstruction, attended with a separation of the muscular or tendinous fibres of the diaphragm. In the only two cases of the accident that have come under my observation, the cause, in one, was a stab in the side, through the sixth intercostal space, and, in the other, a fall from the third-story window of a house upon the brick pavement below. The wound, in both instances, was on the left side, and was large enough to admit nearly the whole of the stomach into the thoracic cavity. One of the persons died in a few hours, the other on the second day. An interesting case has been recorded by Mr. Guthrie, in which the greater part of the stomach and duodenum had passed into the chest through an opening in the diaphragm caused by a Minié ball.

In some cases, the protrusion takes place through a pouch by the side of the œsophagus, aorta, or vena cava. A proper hernial sac exists only when the accident is caused by a gradual separation of the fibres of the diaphragm; in the congenital form, the peritoneum and pleura are directly continuous with each other; and in that following upon wounds and lacerations, the serous membrane is always divided along with the other structures of this musculo-aponeurotic septum. Congenital diaphragmatic hernia may coexist with bifid spine, harelip, or clubfoot, and proves fatal in nearly half the cases at the moment of birth; a few cases survive several months, or a few years, and now and then a person attains to adult age. In diaphragmatic hernia from accident, death may take place instantly, or not for several days, weeks, months, or even years, although the latter event is extremely rare. The diagnosis of the disease is uncertain, and hence little is to be expected from treatment.

j. A very rare form of hernia, consisting in a prolongation of the bowel, was described by Littre in 1700, and is generally known by his name. It is also called diverticular hernia. The protruded part may be simply a congenital diverticulum, a kind of intestinal appendix, or it may exhibit itself as a blind pouch, formed by the mucous and serous coats of the bowel, the muscular having given way. The most common situation of the congenital diverticulum is the lower portion of the ileum, but it may occur also in the jejunum, the colon, and even the rectum. It is composed of the same number of tunics as the intestine, with which it is connected, and varies in length from two to four inches, its diameter being generally a little less than that of the bowel. The accidental pouch, usually very short and narrow, nearly always springs from the ileum, with which it communicates by a small, circular orifice.

Both of these forms of pouches may protrude at the abdominal ring, or at an artificial opening, either alone or in union with a portion of the natural bowel, and, consequently, share the same fate as an ordinary hernia. Mischief will be most likely

to happen when the diverticulum becomes impacted with fecal matter or with some foreign substance, as a pea, cherry-stone, or piece of bone. Unfortunately there are no signs by which such a hernia can be distinguished from a common one. Should symptoms of strangulation arise, they must be met in the usual manner; first by the use of the taxis, and, if this fail, by recourse to the knife.

k. In the *mesocolic hernia* a portion of intestine, generally the small, slips into a sac formed by the layers of the mesocolon. The occurrence is very rare, and the symptoms, when strangulation sets in, are such as characterize the ordinary varieties of the affection.

CHAPTER XV.

DISEASES, INJURIES, AND MALFORMATIONS OF THE ANUS AND RECTUM.

THE affections of the anus and lower bowel are of deep surgical interest, inasmuch as they are not only of frequent occurrence, but a source of much suffering to the patient and of great perplexity to the practitioner. In entering upon their discussion, it may be remarked, by way of introduction, that most, if not all, of the idiopathic diseases of this portion of the body are induced, maintained, or aggravated, by disorder of the digestive, urinary, and genital apparatus, and that it becomes, therefore, a matter of primary importance, as it respects the issue of the treatment, to inquire not only into the nature of their exciting causes, but also, in a special manner, into the condition of the associated organs. No progress can be made in any case without a due consideration of this kind, and without proper attention to the secretions, the bowels, and the diet. Frequent ablutions with water, or, what is better, water and soap, are most valuable auxiliaries, and cooling enemata, either simple or medicated, often remarkably expedite the cure, or, where the disease is irremediable, greatly promote the comfort of the sufferer. When the pain and inflammation are severe, the recumbent posture must be rigidly enjoined, as tending to prevent determination of blood and to allay nervous excitement. The diet, as a general rule, should be plain, simple, and unirritant; all stimulants, both in the form of food and drink, must be carefully avoided; and the mind should be kept in as tranquil a condition as possible. The effect of mental influence upon the progress and termination of diseases of the anus and rectum has not received sufficient consideration from practitioners. Any disturbance of this kind is always highly prejudicial, and should, therefore, be guarded against by every means in our power.

The diagnosis of the diseases of the anus and rectum is determined by the speculum, finger, and bougie. Before any examination, however, is attempted, the lower bowel is thoroughly emptied either by a dose of castor oil, or by a stimulating enema, otherwise there will be serious embarrassment, if not positive failure. This object being accomplished, the patient is placed upon his back across the bed, with the buttocks slightly elevated, and projecting a little beyond the edge of the mattress. The feet may rest upon a high chair, or the knees may be widely separated, and raised towards the chin, so as to expose the perineum; or the patient may lie upon his side, the limbs being strongly flexed upon the pelvis; or, as I usually prefer, he may rest upon his knees and forearms, the head being depressed, and the nates elevated. Whatever posture be adopted, a strong light is necessary to a satisfactory result. The speculum, warmed and well oiled, is then inserted into the anus, gently passed up the rectum, and rotated until the whole of the mucous surface is fairly brought into view. If the canal is obstructed by mucus, blood, pus, or feces, clearance is effected with a sponge mop. The bowel is temporarily plugged with a soft piece of sponge attached to a string, pressed out of warm water, and carried up to a height of three or four inches, removal being effected as soon as the inspection is completed. The best instrument for such an examination is the one represented in fig. 462. The valvular speculum, seen in fig. 463, and so much vaunted by some, is a very inferior contrivance for such an exploration, as it permits the too easy insinuation of the mucous membrane between the blades, thereby preventing accurate inspection. Some prefer a wire instrument, but this also is inferior to the

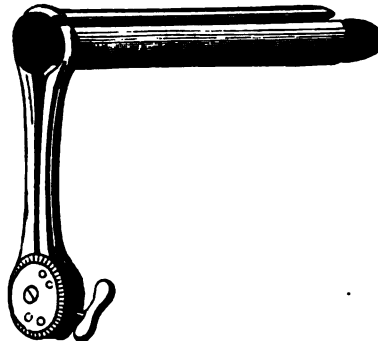
fenestrated one, here delineated. A modification of Sims's vaginal speculum is now much used in this country, and generally answers exceedingly well, especially if the patient, at the time of the inspection, is under the influence of an anæsthetic.

Fig. 462.



Fenestrated Speculum.

Fig. 463.



Valvular Speculum.

In the female, the rectum, as has been shown by Professor H. R. Storer, can readily be everted like a glove through the sphincter muscle of the anus by pressing the finger, inserted into the vagina, downwards and backwards over the elevator muscle. When the parts are unusually tense, irritable, or spasmodically contracted, they should be forcibly stretched with the thumbs as a preliminary measure. The whole of the mucous membrane can by this plan be minutely inspected to a considerable extent, and any application that may be required made with great facility.

Important information may often be derived from the employment of the finger, well oiled, rotated upon its axis as it passes through the sphincters, and carried about in different directions in the interior of the gut; but in stricture, or obstruction from foreign bodies, the diagnosis can hardly be established without the aid of a rectum bougie. In most cases, a delicate probe should be at hand, especially if there be reason to suspect the existence of a fistule, which cannot be properly explored in any other manner.

The administration of *injections* is seldom performed with the care and attention which its importance demands. It is an operation which any one is supposed to be capable of executing, and the consequence is that it is generally done in a very awkward and slovenly manner, without at all attaining the object for which it is undertaken. Simple as, apparently, it is, it requires an amount of skill which few of those who are intrusted with its performance possess. To answer the purpose for which it is intended, the enema should, in the first place, be accurately adapted, by its quantity and quality, to the capacity and tolerance of the bowel; and, in the second, it should be administered in such a manner as not to pain, irritate, or injure the parts. The best instrument for the purpose is a gum-elastic syringe, of the requisite size, with a long, slender nozzle, which should be well oiled, to facilitate its introduction, and carried a considerable distance up the tube, the patient lying upon his side at the edge of the bed, with the thighs somewhat bent upon the abdomen. If the patient is very restive, or unmanageable, as he may be if he is a child, or affected with delirium, he should be carefully held during the operation, otherwise the bowel may be severely wounded, or even perforated, as in an interesting case recorded by the late Professor Pope, of St. Louis, where a child, a few years old, lost his life from this cause. Leudet has reported an instance in which a laceration of the rectum by the syringe caused inflammation of the hemorrhoidal veins, terminating in supuration of the portal vessels.

Whatever may be the object of the enema, whether purgative, stimulant, astringent, or anodyne, no air should be introduced with it, as this is always productive of pain, and frequently completely frustrates the design of the operation. When it is desired to retain the injection for some time, and the bowel is exquisitely irritable, manifesting a constant inclination to throw off its contents, the end may sometimes be attained by the pressure of a warm cloth against the fundament. When it is necessary to employ enemas habitually, a self-injecting instrument, capable of

For the relief of *strangulated* femoral hernia the taxis is employed; early, if possible, to obviate the necessity of an operation, and gently, in order that no harm may befall the compressed and entangled structures. It is of the greatest practical moment to remember that the symptoms here are always, other things being equal, much more urgent than in strangulated inguinal rupture, and that mortification occasionally takes place within less than twenty-four hours after the occurrence of the accident. Time, then, is a matter of immense consequence in nearly all cases of this description. With a view of affording the taxis the best chance of success, particular attention should be paid to the position of the patient, the head, shoulders, and pelvis being thoroughly elevated, the legs flexed upon the thighs, and the thighs upon the pelvis, and both limbs, but especially the affected one, strongly rotated inwards. The object of the latter procedure is to relax, as completely as possible, the lunated margin of the external ring, which, particularly in the more perfectly developed forms of the affection, always exerts a very powerful constricting influence. For want of this precaution, the practitioner, unacquainted with the anatomy of this region, often signally fails in accomplishing his object, whereas, if a proper course were pursued, he would, perhaps, experience little, if any difficulty. The effect which this structure exerts upon the reduction of the protruded parts is well exemplified upon the dead subject, when the limb is alternately everted and inverted after a coil of intestine has been pushed through the femoral canal and brought out at the external ring. It will then be seen that the former movement invariably pinches and compresses the bowel, while the latter relaxes it, and thus places it in a better condition for prompt and safe replacement.

The important rule now described being complied with, and the patient being fully under the influence of anæsthesia, the next step is to draw the tumor downwards and slightly inwards, to efface the elbow which it forms with the femoral canal, and to bring it opposite the external ring. The parts are now pushed directly backwards, so as to get them fairly out of the reach of the lunated edge of the ring, when, the pressure being next made in an upward direction, the reduction is, in general, easily accomplished. It is seldom that the bowel ascends with a gurgling noise, unless the protrusion is large, when the sound may be as distinct as in ordinary inguinal hernia.

The length of time during which the taxis should be persisted in must, of course, be influenced by the circumstances of each particular case; but it may be stated, as a general rule, that it should be considerably less than in hernia of the groin: the efforts, too, should, if possible, be conducted with more gentleness, and no auxiliary measures, save anæsthesia and bloodletting, should ordinarily be called into requisition. If the symptoms are not urgent, or denotive of inflammation of the part and peritoneum, trial may be made, after the first failure of the taxis, of anodynes and topical applications, either cold or warm, care being taken, in the meanwhile, to maintain the body and limbs in a position favorable to spontaneous reduction. If, after a certain period, the protruded parts do not return, or if, after a second effort, the taxis again fail, the symptoms gradually, but steadily, advancing, no time should be lost in having recourse to the knife. To wait longer might endanger both the part and system.

An operation being determined upon, the patient is placed in the same position as in the operation for inguinal hernia, when an incision is made over the upper portion of the tumor, parallel with Poupart's ligament, and intersected by another carried down perpendicularly towards its base; or, instead of this, a T-shaped incision is made; or, if the hernia is very diminutive, a single vertical cut may suffice. The skin and cellular tissue being thus divided, the greatest caution will be required in executing the remaining steps of the operation. Layer after layer is now elevated, and divided upon the grooved director, any lymphatic glands that may be in the way of the knife being pushed aside beyond the reach of harm. The cribriform fascia is often of considerable thickness, especially in corpulent subjects, and, along with the glands involved in its substance, forms a confused mass, difficult to unravel. This having been penetrated, the next structure that presents itself is the anterior layer of the sheath of the femoral vessels, below which, and in immediate contact with the hernial sac, is a thin stratum of cellular tissue, intermixed with a few granules of fat. Dividing this, if possible, with increased caution, the operator next searches for the seat of the stricture, which will usually be found at the lunated edge of the external ring, especially at its outer and upper part, at Gimbernat's liga-

ment, or at Poupart's ligament. This examination may be made with the grooved director, or, what is preferable, with the finger, which is followed immediately with the probe-pointed bistoury, or hernia-knife, with which the resisting structure is slightly notched, the smallest incision being generally sufficient for the purpose. The protruded parts are next gently compressed with a view of unloading the bowel of its contents, and the omentum of its blood, after which they are carefully returned into the abdomen, the sac being left intact. But it may happen that the stricture is seated within the sac, particularly if the hernia is large and old, and then the sac must, of course, be laid open, its division being effected in the same manner as in inguinal hernia, only more cautiously, because the sac is usually drawn very tightly over its contents, and seldom contains more than a few drops of serum. Finally, it may be stated that in femoral hernia, consequent upon wounds, the external coverings are sometimes so extremely thin as to permit the peristaltic motions of the bowel to be seen through them.

In dividing the stricture in femoral hernia, it is of the greatest consequence to remember the relations which the tumor bears to the femoral vein, the epigastric and obturator arteries, and the spermatic cord, lest these important structures should be interfered with, and a copious, if not fatal, hemorrhage be the result. To accomplish this object, the safest rule is to carry the knife upwards with a very slight inclination inwards, and to keep it as much as possible behind Poupart's ligament. If the instrument were to be directed outwards, the femoral vein might be punctured, as has happened in more than one instance; if inwards, the spermatic cord might be endangered; and if too far forwards, the obturator artery, should it lie in front of the tumor, as it does when it is given off by the epigastric, might be wounded. Seeing how closely the tumor is embraced by these important structures, the surgeon should be most cautious in his movements, taking care, above all things, to make as little use of the knife as possible in dividing the stricture. It would be well, indeed, if the edge of the instrument were quite blunt, and if the necessary division were effected with a kind of sawing motion, as such a procedure would afford the vessels in question a better opportunity of escaping injury. Should hemorrhage, however, arise, despite the utmost precaution, it must at once be arrested by the ligature; or, when this is impracticable, on account of the inaccessible situation of the vessel, by means of pressure, either with the finger of a relay of assistants, or an appropriate compress and bandage, retained until all danger of bleeding is over.

The after-treatment is the same as in inguinal hernia; and similar precautions are necessary in regard to the use of the truss when the patient begins to walk about.

Anomalous Forms of Femoral Hernia.—In addition to the varieties of femoral rupture above described, there are several others, which, although extremely rare, deserve brief notice. These anomalies, for so they should be considered, refer chiefly to the passage of the protruded parts and the relation which they bear to the neighboring vessels, and to the shape, size, and contents of the tumor.

Hesselbach mentions an instance in which the sac of the rupture had descended behind Poupart's ligament, between the femoral vessels and the anterior superior spinous process of the ilium. It lay under cover of the iliac portion of the femoral aponeurosis, its neck being crossed by the internal circumflex iliac artery. Mr. Stanley met with one in which the sac, about the size of a walnut, lay directly in front of the vessels; and in another case, mentioned by the same author, it passed out of the abdomen external to these vessels, but close to them. A similar example has been recorded by Mr. Partridge.

Cloquet also describes a case in which the parts had descended in front of the vessels of the thigh. The same anatomist saw an instance in which the tumor had passed through an opening in the posterior part of the sheath, so that it lay immediately upon the pectineal muscle, and, consequently, behind the artery and vein, separated from them only by the deep-seated portion of the fascia. Similar examples have been observed by Callisen, Le Gendre, Richet, Adams, and others.

There is a variety of femoral hernia, first noticed by Langier, in which the bowel passes through the fibres of Gimbernat's ligament. It lies, of course, internal to, and at a considerable distance from, the great vessels.

In nearly all of these anomalous cases the epigastric artery, or this vessel and the obturator, is intimately connected with the sac of the hernia, either crossing it

in front, or running closely along its inner surface. Hence, if the point of the knife be used in the division of the stricture or the deep-seated coverings of the tumor, a troublesome, if not a fatal, hemorrhage will almost be inevitable.

The surface of the femoral hernia, instead of being smooth and uniform, as it generally is, is sometimes remarkably constricted, having a kind of hour-glass appearance, caused either by the passage of a vessel of considerable size, or by the unequal compression of the overlying fascia.

Occasionally, again, the sac is multilocular, or divided into several compartments. In a case mentioned by Monro there were not less than four such cavities, of which three communicated with each other.

The parts are sometimes included in a double sac. Chevalier met with two instances in which a sac containing bowel lay within another sac, in such a manner as to fill up completely the aperture, to which it was firmly adherent. A similar case has been reported by Dupuytren.

Ordinarily the femoral rupture is very diminutive, its volume not exceeding that of a small almond or a pigeon's egg. Now and then, however, an instance occurs in which the tumor descends half way down the thigh, or fills up almost completely the space between the anterior superior spinous process of the ilium and the pubic symphysis. A unique case of a large femoral hernia, the walls of which were so thin as to permit the peristaltic motion of the bowel to be perceived, has been recorded by Thompson.

Although the femoral hernia is generally composed entirely of intestine, an instance occasionally occurs where the contents are exclusively omental. In a case of double femoral rupture in an old lady, whose body I examined after death, each tumor contained merely a process of omentum, one of which had become much enlarged and indurated from its protracted imprisonment.

UMBILICAL HERNIA.

In umbilical hernia the abdominal viscera are protruded at the umbilical ring, or what is vulgarly called the navel. The complaint is much more frequent in women than in men. Thus, of 2775 cases of umbilical hernia reported by the London Truss Society, 2111 occurred in the female, and only 664 in the male, or in the proportion of about $3\frac{1}{4}$ to 1. The affection displays some variety according as it shows itself in the fœtus, in the infant, and in the adult.

In the Fœtus.—Umbilical hernia of the fœtus is always dependent upon defective development of the walls of the abdomen, and is frequently associated with malformation of other parts of the body, as harelip, bifid spine, clubfoot, or exstrophy of the bladder. In one case under my care, the infant had hypospadias and an additional finger on each hand.

The contents of an umbilical hernia usually consist of a coil of the small intestine, or of this portion of the bowel and of the colon, sometimes of the liver, occasionally of the spleen, and now and then, but very rarely, of the stomach. The affection has been noticed at a very early period of fœtal existence, although it is most common during the latter stages of pregnancy. The tumor varies in volume, according to the extent of the deficiency in the parietes of the abdomen, from that of a thimble to that of a fist. It has a proper hernial sac, but no cutaneous covering, its external investment consisting of the transparent envelop of the umbilical cord, united to the peritoneum by a thin layer of cellular tissue. The umbilical vessels are sometimes separated by the protruded viscera, and the cord is generally situated at the inferior margin of the tumor, or a little to one side of it.

When the umbilical tumor is large, death usually takes place within a few days after birth, from the effects apparently of peritoneal irritation. If the child survives, an attempt may be made to bring about a permanent cure by transfixing the edges of the umbilical ring with several delicate pins, and winding around each, in an elliptical form, a well-waxed ligature, as in the common harelip suture. In performing the operation, care is taken not to interfere in the slightest degree with the peritoneum; the pins should be retained the better part of a week, and the abdomen should be thoroughly supported in the interval, as well as for some time after, by broad strips of adhesive plaster, or a gum-elastic bandage.

In the Child.—Umbilical hernia in the child generally comes on within the first

two or three months after birth, and cases occur where it is congenital, or where it appears soon after the first severe paroxysm of crying. Whatever may be the period of its evolution, the immediate cause of the disease is a succession of violent muscular efforts, by which the abdominal viscera are forcibly impelled against the umbilical aperture, before it has had time to become completely obliterated. The tumor, which rarely exceeds a common marble in bulk, is either hemispherical or conical, soft and gaseous in its consistence, and sensibly impressed by crying, laughing, coughing, or sneezing; retiring under pressure, and reappearing immediately when the pressure is removed. If, after the reduction has been effected, the finger be inserted into the opening, it will be found to be of a circular shape, with sharp, well-defined edges. The coverings of the tumor are the skin, cellular tissue, and peritoneum, its ordinary contents being small intestine; very rarely omentum, or omentum and intestine. In a case related by Cabrolus, the hernia consisted solely of the bladder, the child, a female, having been born with obstruction of the urethra. The organ soon gave way externally, so as to admit of the free discharge of the urine in this direction. At the age of eighteen, however, the natural channel was restored by operation, the fistule closed, and the hernia gradually disappeared.

An umbilical hernia in the child must be treated upon the same general principles as a similar rupture in the adult. If the disorder receives early attention, a radical cure may often be effected in a very short time, as there is always, at this period, a great tendency to contraction of the umbilical ring. Sometimes, indeed, the hernia disappears spontaneously, even after it has made considerable progress, especially when the general health is good, when there is not much obesity, and, above all, when care is taken to avoid the exciting causes of the complaint. Such a fortunate event, however, is very uncommon; hence, the best plan always is not to wait for it, but to treat the case at once with a retentive apparatus, adapted to the age and comfort of the little sufferer. The contrivance from which most benefit is to be expected is a leather, wooden, ivory, gutta-percha, or metallic pad, of a circular shape, perfectly flat, large enough to overlap the edges of the ring, and confined by a few broad strips of adhesive plaster, carried completely around the body. Over this, a broad gum-elastic band should be worn, in order to give due support to the whole abdomen. If the child has attained the age of two or three years, a proper truss should be used, such as that worn in this variety of hernia in the adult. If, under this treatment, a radical cure be not effected, the edges of the ring should be transfixed by a stout silver needle, fastened by a ligature, and retained until firm union is obtained. The subcutaneous wire suture might also be tried. No danger would be likely to result from either procedure. If strangulation should occur, and an operation be demanded, opening of the sac must be carefully avoided, lest fatal peritonitis should be provoked.

In the Adult.—In the umbilical hernia in the adult the tumor is usually globular, or pyriform, and, from not being larger originally than the end of the finger, it may, as it increases in age, acquire an enormous volume, extending, perhaps, as low down as the pubes. In corpulent persons it often manifests a disposition to insinuate itself beneath the skin, within the adipose matter, and the consequence is that it sometimes forms hardly any perceptible enlargement, as it does when the subject is emaciated. A hernia in such a state is peculiarly dangerous if it happen to become strangulated, from its liability to be overlooked, and, therefore, mismanaged. An instance of a fatal mistake of this kind occurred, some years ago, in the hands of a medical friend, a man of great intelligence, who never suspected the true nature of the disease until it was revealed by dissection after death. The patient was a married woman, whose abdomen was loaded with an enormous quantity of fat, beneath which a large, strangulated umbilical hernia existed.

An umbilical hernia in the adult generally contains omentum, or omentum and a portion of the colon; sometimes small intestine, but very rarely alone. The stomach and other viscera are occasionally included in it. Many years ago I dissected the body of a woman, the mother of three children, in whom the hernia was composed exclusively of the gravid uterus, near the full period of gestation. The centre of the tumor bore distinct evidence of the remains of the umbilicus. A similar case has been described by Murray. An instance of a double umbilical hernia occasionally occurs. The coverings of the tumor consist of the skin, superficial fascia, and peritoneum, the latter of which, especially in cases of long standing,

is sometimes very thin, or thin at one point and thickened at another. The umbilical ring is generally towards the upper part of the tumor.

The most common causes of this form of rupture are laborious parturition, pregnancy, and habitual straining at stool. Females are much more subject to it than males, and fat persons than lean; it is rarely met with before the age of twenty-five or thirty, or until after the abdomen has become enlarged and pendulous from incessant distention of its walls. Constipation of the bowels, flatulence, colicky pains, nausea, and other evidence of gastro-intestinal disorder are common attendants upon this variety of hernia. An instance in which strangulation of the small bowel occurred in an old hernia of this kind, in consequence of an opening formed in the umbilicus by ulceration, has been reported by Dr. T. L. Ogier, of Charleston, South Carolina.

The diagnosis of umbilical hernia is generally sufficiently easy. When any difficulty arises it is usually due to the existence of a fatty tumor, an instance of which occasionally occurs in the linea alba, where, especially if it is small, it may be mistaken for an omental rupture. Scarpa very candidly confesses that he once committed an error of this kind. A woman was seized with colic and nausea, accompanied with constipation and painful tympanites. A tumor, the size of a large nut, existed just below the umbilicus, on the left side of the middle line. Convinced that it was a strangulated hernia, an operation was performed, when it was ascertained that the tumor was merely a small mass of hard fat.

The means best calculated for the retention of a small umbilical rupture in the adult is a truss with a wooden block, at least two inches in diameter, slightly convex upon its abdominal surface, and secured to an elastic spring, long enough to encircle the body. The ends of the spring should be fastened behind to a broad, oblong pad, six inches in length, and arched transversely, to adapt it the more accurately to the spine. When there is much obesity, or great volume of tumor, the block should be proportionately larger, and the operation of the instrument should be aided by a gum-elastic supporter, which, by taking off the weight of the abdominal viscera, will thus serve to diffuse and equalize their pressure against the abdominal parietes. No truss that does not combine these qualities can be considered, under such circumstances, as of much value; for, although a radical cure can seldom be effected in any case, there is hardly a tumor, however large, inconvenient, or painful, that may not be materially relieved by these means. As to the blocks and pads with a central prominence, until lately so much used in this country, it would be difficult to conceive how they could produce any other than an injurious effect, as their action must inevitably be to separate still farther the edges of the umbilical ring into which the knob projects.

One of the peculiarities of the umbilical hernia in the adult is that, if neglected or mismanaged, it soon becomes irreducible, either from the enlargement of its contents, or from their adhesion to each other and to the inner surface of the sac. Hence, every possible endeavor should be used to prevent this occurrence, or, if this be impracticable, to restrict it within the smallest possible limits by suitable anti-phlogistic and retentive means. The existence of tenderness and pain in the tumor, constipation of the bowels, nausea, and general uneasiness in the abdomen, should be attentively watched, and regarded with suspicion. Should the symptoms increase instead of diminishing, blood should be abstracted by the lancet and by leeches, the rectum stimulated by injections, and the belly well fomented with hot water and laudanum. To aid in the removal of plastic matter, small doses of mercury may be used for some time after, and sorbefacients applied to the tumor. If, notwithstanding these precautions, the hernia remains irreducible, or if it was so before the surgeon was consulted, timely measures must be employed for the prevention of its further increase, as well as for its protection against external injury. The most efficient and convenient apparatus for this purpose is a hollow truss, cup-shaped, well padded, and retained in place by a scapulary, or the addition of a gum-elastic supporter. To obviate griping, flatulence, and dyspepsia, a concentrated, easily digestible diet and a soluble state of the bowels should be enjoined.

If strangulation ensues, no time should be lost in employing the taxis, the patient being anesthetized, and placed pretty much in the same position as under similar circumstances in the other varieties of hernia. If the tumor is at all bulky, its contents, after having been drawn away from the umbilical ring, must be pressed

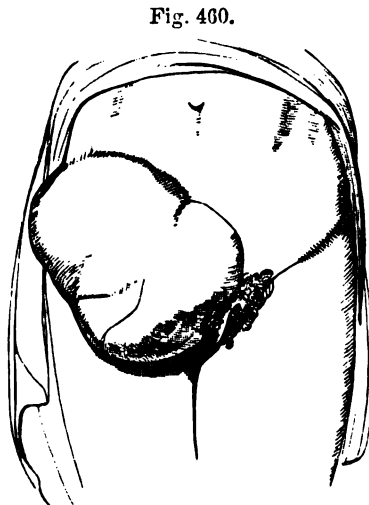
quent in the former than in the latter. It is naturally closed by a lymphatic gland and a small quantity of cellulo-fatty matter, which thus generally offer not a little resistance to the descent of the abdominal viscera. The external femoral ring, usually called the saphenous opening, because it is here that the saphenous vein empties into the great femoral, is of an ovoidal shape, very spacious, and bounded by the crescentic edge which is formed here by the femoral aponeurosis. It is occupied by a number of lymphatic glands, as well as by a large mass of dense, cellulo-adipose substance, forming what is termed the cribriform fascia, a structure playing an important part in the anatomy of femoral hernia. The canal between the two openings now described is very short, especially in front, its wall here being formed solely by the upper lunated border of the external ring, known as Hey's ligament. The posterior wall, on the contrary, is much longer, and is represented by the pubic portion of the femoral aponeurosis. Thus constituted, the passage is lined by a prolongation of the transverse fascia in front and of the iliac behind, together with a thin layer of cellulo-adipose tissue, which, lying immediately beneath the former fascia, is continuous above with the cellulo-fatty matter which aids in filling up the internal ring, and below with the cribriform fascia. This substance, it may now be remarked, forms what is called the proper fascia of femoral hernia.

The abdominal viscera, passing down the thigh, through the openings here described, clothe themselves with a portion of peritoneum, which thus, as in the other varieties of the complaint, constitutes the proper hernial sac. If, therefore, a dissection be made of the coverings of the tumor, extending from without inwards, they will be found to present themselves in the following order:—skin, superficial fascia, cribriform fascia, the funnel-shaped process of the transverse fascia, the proper fascia, and, lastly, the peritoneum. The position of the epigastric artery and the spermatic cord is deserving of particular notice in relation to this variety of rupture. The former always lies on the outside of the tumor, close to its neck, while the latter lies above and internally. The obturator artery, when given off by a trunk common to it and the epigastric, as it is supposed to be in every fourth case, arranges itself along the anterior and upper part of the tumor.

The contents of a femoral hernia usually consist exclusively of small intestine, generally a portion of the ileum, especially in cases of recent standing; but under opposite circumstances, and, in particular, when the tumor is bulky, both bowel and

omentum frequently enter into its composition. Instances in which omentum alone protrudes are by no means uncommon; and I have a preparation, taken from a lady upwards of seventy years of age, who had long labored under double femoral rupture, in which the contents are exclusively of this character. Examples are met with, although rarely, in which the tumor is composed of the ovary and Fallopian tube, of the uterus, or of the uterus, Fallopian tube, ovary, and vagina. A case has been recorded in which the urinary bladder was the part protruded. Femoral hernia occasionally coexists with inguinal.

The tumor in femoral hernia is always small compared with that of inguinal hernia, seldom exceeding the size of an almond, and occasionally hardly attaining that of a nutmeg. Sometimes, however, its bulk is quite extraordinary, equalling that of a fist, or even that of a foetal head, as in fig. 460. In the latter case, the tumor is commonly of a globular shape, whereas, ordinarily, it is of an elongated ovoidal figure, longer



Femoral Hernia, of very Large Size.

in the transverse diameter than in the vertical. The hernia may be complete or incomplete, as in the inguinal varieties of the complaint. In the former case, the viscera escape at the external ring, and form a tumor which lies on the upper and inner surface of the thigh, immediately below Poupart's ligament, and a little external to the spine of the pubes. In order to reach this point, the parts are obliged, upon arriving at the external ring, to change their direction, passing upwards towards

the groin instead of downwards towards the knee, and in doing this the two portions are doubled upon each other. The reason of this change of direction, a knowledge of which is so important in relation to the proper employment of the taxis, is the manner in which the saphenous vein enters the femoral, and the peculiar connection of the cellular tissue at the lower margin of the external ring, with the femoral aponeurosis. The barrier thus formed, however, is sometimes broken down, and then the hernia not only descends along the thigh, but often acquires an extraordinary bulk from the restraint being thus taken off. In the incomplete form of the disorder, the tumor is always very small; and it is on this account that the true nature of the case is very liable to be overlooked, the intercepted portion of bowel occasionally not exceeding one-third, one-half, or two-thirds of the diameter of the tube. It is, in fact, a most dangerous form of hernia, similar, in every respect, to concealed, interstitial, or interparietal hernia of the groin, described on a previous page. In the case from which the sketch, fig. 461, was taken, the protruded part was hardly the size of a pea-nut without its shell.

Femoral hernia, as already stated, is much more frequent in women than in men. Of 6210 cases reported by the London Truss Society, 5511 were females, and 699 were males, or nearly in the ratio of 8 to 1. Of 407 cases analyzed by Frickhöffer, 352 occurred in females and only 55 in males. The complaint is occasionally noticed in children, but very seldom before the twelfth year.

Diagnosis.—Femoral hernia is liable to be mistaken for other affections, from which it is of the greatest consequence that it should be distinguished. Of these the most important are inguinal hernia, psoas abscess, varix of the saphenous vein, and enlargement of the lymphatic glands.

In regard to the distinction between femoral and *inguinal hernia*, little difficulty can arise if it be remembered that, in the former, the neck of the tumor is below Poupart's ligament, while in the latter it is above. A good plan, therefore, in cases of doubt, is to trace the course of this ligament along its inner half with the finger, when, if it be found to be overlapped by the swelling, it may be assumed that the hernia is inguinal, it being well known that a femoral hernia rarely, if ever, ascends so high up. Besides, important information may be gained by a careful examination of the inguinal and femoral rings, the former of which, in particular, will always readily admit the tip of the finger when it is not occupied by the abdominal viscera. The size and shape of the tumor are not to be disregarded. In femoral hernia it is small and transversely elongated; in inguinal, on the contrary, it is comparatively large, and of an irregular, hemispherical shape. In the former, the tumor is fixed, and, when strangulated, soon becomes very tender; in the latter, it is movable, and does not suffer so early, nor are the constitutional symptoms usually so urgent.

A consideration of the sex is not to be disregarded in the investigation. Femoral hernia, as before stated, is much more common in women than in men. Age also is important. Inguinal rupture is liable to occur at any period of life; femoral, on the contrary, is seldom seen until after the fortieth year, and is by far most frequent in elderly subjects.

Psoas abscess occasionally points beneath Poupart's ligament, forming a tumor, of variable size and shape, at the upper and inner part of the thigh, which may be mistaken for femoral hernia. The error will be most likely to occur when the swelling is small and recent; even then, however, a little care will generally suffice to establish the diagnosis. The best guides are the history of the case, the flexed condition of the thigh, with a certain degree of lameness, and the fact that the swelling always readily disappears under pressure during recumbency.

Varix of the saphenous vein at its entrance into the femoral, or of both vessels at this point, is sometimes met with, and has occasionally been treated as a femoral rupture. Such an error implies the most culpable carelessness, for it could certainly not be committed by any one who has the slightest tact or experience in examining

Fig. 461.



Femoral Hernia, Strangulated by a very Small Part of the Bowel being caught in the Femoral ring.

patients. The diagnosis will always be easy when it is recollected that a varix is much softer than a femoral hernia; that it has a peculiar knotty feel; that it always coexists with varicose enlargement of the saphenous vein below; and that, after having been effaced by manipulation, it speedily reappears under pressure applied to the femoral vein just above the external ring, when the patient stands up, no such effect following if the tumor be hernial.

The *lymphatic glands*, at the upper and inner part of the thigh, are liable to enlargement, both acute and chronic, and numerous instances have occurred of error of diagnosis between this disease and femoral hernia, a rupture having been laid open for a supposed abscess, and an inflamed gland treated as a rupture. It is perhaps, not always easy to discriminate between these two affections; but it is hardly possible to conceive of a case where a careful examination of the part and a proper inquiry into the previous symptoms would not promptly dispel all doubt in relation to its real character. When symptoms of strangulation exist along with a tumor of a suspicious nature, and one which does not promptly yield to antiphlogistic measures, the rule is to operate, both in this and in other varieties of hernia. What complicates these cases occasionally, and embarrasses the diagnosis, is the coexistence of glandular enlargement and femoral hernia, the latter of which is then apt to be very small and concealed by the former.

Treatment.—Reducible femoral hernia must be treated with a well-adjusted truss, constructed upon the same principles as that used for inguinal hernia. It should rest over the hips midway between the crest of the ilium and the great trochanter, and should be provided with a small, slender block, very convex on the surface, and fastened to its spring nearly at a right angle. The object should be to concentrate the pressure as much as possible, which cannot be done when the pad is broad and flat, on account of the constant motion of the pectineal muscle. Care must be taken not to permit the block to exert any injurious compression upon the femoral vein, which, by embarrassing the return of the blood, might thus occasion serious mischief in the limb below, as anasarca, and even active inflammation. The precise spot where the pressure is to be made is just below Poupart's ligament, and a little external to the spine of the pubes, directly in the line of the femoral canal and the upper portion of the external ring, it being impossible, by any contrivance yet devised, to concentrate the pressure upon the internal ring. It is for this reason, in part, that a femoral hernia is so seldom radically relieved, the other causes of failure being found in the peculiar nature of the boundaries of the internal ring, these being partly osseous and partly ligamentous, and, therefore, in great measure, insusceptible of adhesive action. A truss, then, in this variety of rupture, should be worn rather as a retentive apparatus than as one designed to bring about a permanent cure. Owing to the circumstance, however, just alluded to, it is questionable whether a small portion of the hernia does not generally remain above the block of the instrument, within the mouth of the internal ring.

The *irreducible* hernia of the thigh is best supported by a truss with a hollow pad, so arranged as to receive and accommodate the protruded mass, and thus protect it from further increase, as well as from external injury. A piece of tin, silver, or gutta-percha, adapted to the shape of the tumor, well padded, and provided with a narrow margin, would answer a good purpose in such a case. The neck of the pad, or the part which intervenes between the pad and the spring of the truss, might be composed of some elastic substance, to enable these two portions to move upon each other in the various attitudes of the thigh and body. A proper support of this form of rupture is particularly important, since, if it be permitted to increase, it may acquire a large bulk, and thus greatly interfere with the patient's occupation, not to mention other inconvenience, and the risk of strangulation.

A case of partially irreducible femoral hernia, radically cured by operation, was recently communicated to me by Dr. A. Ball, of Zanesville, Ohio. The patient, a woman, forty-eight years of age, had an old rupture, the size of a goose's egg, of an elongated, ovoidal shape, in the centre of which was a hard substance, which, upon removal, was found to be the right ovary, attached by a short pedicle, and surrounded by at least six ounces of limpid fluid. The sac containing the bowel seemed to be separate from that in which the ovary was situated; it was dissected up as far as its attachment to the femoral ring, and then carefully cut off, a silk ligature having previously been thrown around its neck. The wound was closed by suture, and a rapid recovery followed without any untoward symptoms.

For the relief of *strangulated* femoral hernia the taxis is employed; early, if possible, to obviate the necessity of an operation, and gently, in order that no harm may befall the compressed and entangled structures. It is of the greatest practical moment to remember that the symptoms here are always, other things being equal, much more urgent than in strangulated inguinal rupture, and that mortification occasionally takes place within less than twenty-four hours after the occurrence of the accident. Time, then, is a matter of immense consequence in nearly all cases of this description. With a view of affording the taxis the best chance of success, particular attention should be paid to the position of the patient, the head, shoulders, and pelvis being thoroughly elevated, the legs flexed upon the thighs, and the thighs upon the pelvis, and both limbs, but especially the affected one, strongly rotated inwards. The object of the latter procedure is to relax, as completely as possible, the lunated margin of the external ring, which, particularly in the more perfectly developed forms of the affection, always exerts a very powerful constricting influence. For want of this precaution, the practitioner, unacquainted with the anatomy of this region, often signally fails in accomplishing his object, whereas, if a proper course were pursued, he would, perhaps, experience little, if any difficulty. The effect which this structure exerts upon the reduction of the protruded parts is well exemplified upon the dead subject, when the limb is alternately everted and inverted after a coil of intestine has been pushed through the femoral canal and brought out at the external ring. It will then be seen that the former movement invariably pinches and compresses the bowel, while the latter relaxes it, and thus places it in a better condition for prompt and safe replacement.

The important rule now described being complied with, and the patient being fully under the influence of anaesthesia, the next step is to draw the tumor downwards and slightly inwards, to efface the elbow which it forms with the femoral canal, and to bring it opposite the external ring. The parts are now pushed directly backwards, so as to get them fairly out of the reach of the lunated edge of the ring, when, the pressure being next made in an upward direction, the reduction is, in general, easily accomplished. It is seldom that the bowel ascends with a gurgling noise, unless the protrusion is large, when the sound may be as distinct as in ordinary inguinal hernia.

The length of time during which the taxis should be persisted in must, of course, be influenced by the circumstances of each particular case; but it may be stated, as a general rule, that it should be considerably less than in hernia of the groin: the efforts, too, should, if possible, be conducted with more gentleness, and no auxiliary measures, save anaesthesia and bloodletting, should ordinarily be called into requisition. If the symptoms are not urgent, or denotive of inflammation of the part and peritoneum, trial may be made, after the first failure of the taxis, of anodynes and topical applications, either cold or warm, care being taken, in the meanwhile, to maintain the body and limbs in a position favorable to spontaneous reduction. If, after a certain period, the protruded parts do not return, or if, after a second effort, the taxis again fail, the symptoms gradually, but steadily, advancing, no time should be lost in having recourse to the knife. To wait longer might endanger both the part and system.

An operation being determined upon, the patient is placed in the same position as in the operation for inguinal hernia, when an incision is made over the upper portion of the tumor, parallel with Poupart's ligament, and intersected by another carried down perpendicularly towards its base; or, instead of this, a T-shaped incision is made; or, if the hernia is very diminutive, a single vertical cut may suffice. The skin and cellular tissue being thus divided, the greatest caution will be required in executing the remaining steps of the operation. Layer after layer is now elevated, and divided upon the grooved director, any lymphatic glands that may be in the way of the knife being pushed aside beyond the reach of harm. The cribriform fascia is often of considerable thickness, especially in corpulent subjects, and, along with the glands involved in its substance, forms a confused mass, difficult to unravel. This having been penetrated, the next structure that presents itself is the anterior layer of the sheath of the femoral vessels, below which, and in immediate contact with the hernial sac, is a thin stratum of cellular tissue, intermixed with a few granules of fat. Dividing this, if possible, with increased caution, the operator next searches for the seat of the stricture, which will usually be found at the lunated edge of the external ring, especially at its outer and upper part, at Gimbernat's liga-

ment, or at Poupart's ligament. This examination may be made with the grooved director, or, what is preferable, with the finger, which is followed immediately with the probe-pointed bistoury, or hernia-knife, with which the resisting structure is slightly notched, the smallest incision being generally sufficient for the purpose. The protruded parts are next gently compressed with a view of unloading the bowel of its contents, and the omentum of its blood, after which they are carefully returned into the abdomen, the sac being left intact. But it may happen that the stricture is seated within the sac, particularly if the hernia is large and old, and then the sac must, of course, be laid open, its division being effected in the same manner as in inguinal hernia, only more cautiously, because the sac is usually drawn very tightly over its contents, and seldom contains more than a few drops of serum. Finally, it may be stated that in femoral hernia, consequent upon wounds, the external coverings are sometimes so extremely thin as to permit the peristaltic motions of the bowel to be seen through them.

In dividing the stricture in femoral hernia, it is of the greatest consequence to remember the relations which the tumor bears to the femoral vein, the epigastric and obturator arteries, and the spermatic cord, lest these important structures should be interfered with, and a copious, if not fatal, hemorrhage be the result. To accomplish this object, the safest rule is to carry the knife upwards with a very slight inclination inwards, and to keep it as much as possible behind Poupart's ligament. If the instrument were to be directed outwards, the femoral vein might be punctured, as has happened in more than one instance; if inwards, the spermatic cord might be endangered; and if too far forwards, the obturator artery, should it lie in front of the tumor, as it does when it is given off by the epigastric, might be wounded. Seeing how closely the tumor is embraced by these important structures, the surgeon should be most cautious in his movements, taking care, above all things, to make as little use of the knife as possible in dividing the stricture. It would be well, indeed, if the edge of the instrument were quite blunt, and if the necessary division were effected with a kind of sawing motion, as such a procedure would afford the vessels in question a better opportunity of escaping injury. Should hemorrhage, however, arise, despite the utmost precaution, it must at once be arrested by the ligature; or, when this is impracticable, on account of the inaccessible situation of the vessel, by means of pressure, either with the finger of a relay of assistants, or an appropriate compress and bandage, retained until all danger of bleeding is over.

The after-treatment is the same as in inguinal hernia; and similar precautions are necessary in regard to the use of the truss when the patient begins to walk about.

Anomalous Forms of Femoral Hernia.—In addition to the varieties of femoral rupture above described, there are several others, which, although extremely rare, deserve brief notice. These anomalies, for so they should be considered, refer chiefly to the passage of the protruded parts and the relation which they bear to the neighboring vessels, and to the shape, size, and contents of the tumor.

Hesselbach mentions an instance in which the sac of the rupture had descended behind Poupart's ligament, between the femoral vessels and the anterior superior spinous process of the ilium. It lay under cover of the iliac portion of the femoral aponeurosis, its neck being crossed by the internal circumflex iliac artery. Mr. Stanley met with one in which the sac, about the size of a walnut, lay directly in front of the vessels; and in another case, mentioned by the same author, it passed out of the abdomen external to these vessels, but close to them. A similar example has been recorded by Mr. Partridge.

Cloquet also describes a case in which the parts had descended in front of the vessels of the thigh. The same anatomist saw an instance in which the tumor had passed through an opening in the posterior part of the sheath, so that it lay immediately upon the pectineal muscle, and, consequently, behind the artery and vein, separated from them only by the deep-seated portion of the fascia. Similar examples have been observed by Callisen, Le Gendre, Richet, Adams, and others.

There is a variety of femoral hernia, first noticed by Laugier, in which the bowel passes through the fibres of Gimbernat's ligament. It lies, of course, internal to, and at a considerable distance from, the great vessels.

In nearly all of these anomalous cases the epigastric artery, or this vessel and the obturator, is intimately connected with the sac of the hernia, either crossing it

in front, or running closely along its inner surface. Hence, if the point of the knife be used in the division of the stricture or the deep-seated coverings of the tumor, a troublesome, if not a fatal, hemorrhage will almost be inevitable.

The surface of the femoral hernia, instead of being smooth and uniform, as it generally is, is sometimes remarkably constricted, having a kind of hour-glass appearance, caused either by the passage of a vessel of considerable size, or by the unequal compression of the overlying fascia.

Occasionally, again, the sac is multilocular, or divided into several compartments. In a case mentioned by Monro there were not less than four such cavities, of which three communicated with each other.

The parts are sometimes included in a double sac. Chevalier met with two instances in which a sac containing bowel lay within another sac, in such a manner as to fill up completely the aperture, to which it was firmly adherent. A similar case has been reported by Dupuytren.

Ordinarily the femoral rupture is very diminutive, its volume not exceeding that of a small almond or a pigeon's egg. Now and then, however, an instance occurs in which the tumor descends half way down the thigh, or fills up almost completely the space between the anterior superior spinous process of the ilium and the pubic symphysis. A unique case of a large femoral hernia, the walls of which were so thin as to permit the peristaltic motion of the bowel to be perceived, has been recorded by Thompson.

Although the femoral hernia is generally composed entirely of intestine, an instance occasionally occurs where the contents are exclusively omental. In a case of double femoral rupture in an old lady, whose body I examined after death, each tumor contained merely a process of omentum, one of which had become much enlarged and indurated from its protracted imprisonment.

UMBILICAL HERNIA.

In umbilical hernia the abdominal viscera are protruded at the umbilical ring, or what is vulgarly called the navel. The complaint is much more frequent in women than in men. Thus, of 2775 cases of umbilical hernia reported by the London Truss Society, 2111 occurred in the female, and only 664 in the male, or in the proportion of about $3\frac{1}{4}$ to 1. The affection displays some variety according as it shows itself in the fœtus, in the infant, and in the adult.

In the Fœtus.—Umbilical hernia of the fœtus is always dependent upon defective development of the walls of the abdomen, and is frequently associated with malformation of other parts of the body, as harelip, bifid spine, clubfoot, or exstrophy of the bladder. In one case under my care, the infant had hypospadias and an additional finger on each hand.

The contents of an umbilical hernia usually consist of a coil of the small intestine, or of this portion of the bowel and of the colon, sometimes of the liver, occasionally of the spleen, and now and then, but very rarely, of the stomach. The affection has been noticed at a very early period of fœtal existence, although it is most common during the latter stages of pregnancy. The tumor varies in volume, according to the extent of the deficiency in the parietes of the abdomen, from that of a thimble to that of a fist. It has a proper hernial sac, but no cutaneous covering, its external investment consisting of the transparent envelop of the umbilical cord, united to the peritoneum by a thin layer of cellular tissue. The umbilical vessels are sometimes separated by the protruded viscera, and the cord is generally situated at the inferior margin of the tumor, or a little to one side of it.

When the umbilical tumor is large, death usually takes place within a few days after birth, from the effects apparently of peritoneal irritation. If the child survives, an attempt may be made to bring about a permanent cure by transfixing the edges of the umbilical ring with several delicate pins, and winding around each, in an elliptical form, a well-waxed ligature, as in the common harelip suture. In performing the operation, care is taken not to interfere in the slightest degree with the peritoneum; the pins should be retained the better part of a week, and the abdomen should be thoroughly supported in the interval, as well as for some time after, by broad strips of adhesive plaster, or a gum-elastic bandage.

In the Child.—Umbilical hernia in the child generally comes on within the first

two or three months after birth, and cases occur where it is congenital, or where it appears soon after the first severe paroxysm of crying. Whatever may be the period of its evolution, the immediate cause of the disease is a succession of violent muscular efforts, by which the abdominal viscera are forcibly impelled against the umbilical aperture, before it has had time to become completely obliterated. The tumor, which rarely exceeds a common marble in bulk, is either hemispherical or conical, soft and gaseous in its consistence, and sensibly impressed by crying, laughing, coughing, or sneezing; retiring under pressure, and reappearing immediately when the pressure is removed. If, after the reduction has been effected, the finger be inserted into the opening, it will be found to be of a circular shape, with sharp, well-defined edges. The coverings of the tumor are the skin, cellular tissue, and peritoneum, its ordinary contents being small intestine; very rarely omentum, or omentum and intestine. In a case related by Cabrolus, the hernia consisted solely of the bladder, the child, a female, having been born with obstruction of the urethra. The organ soon gave way externally, so as to admit of the free discharge of the urine in this direction. At the age of eighteen, however, the natural channel was restored by operation, the fistule closed, and the hernia gradually disappeared.

An umbilical hernia in the child must be treated upon the same general principles as a similar rupture in the adult. If the disorder receives early attention, a radical cure may often be effected in a very short time, as there is always, at this period, a great tendency to contraction of the umbilical ring. Sometimes, indeed, the hernia disappears spontaneously, even after it has made considerable progress, especially when the general health is good, when there is not much obesity, and, above all, when care is taken to avoid the exciting causes of the complaint. Such a fortunate event, however, is very uncommon; hence, the best plan always is not to wait for it, but to treat the case at once with a retentive apparatus, adapted to the age and comfort of the little sufferer. The contrivance from which most benefit is to be expected is a leather, wooden, ivory, gutta-percha, or metallic pad, of a circular shape, perfectly flat, large enough to overlap the edges of the ring, and confined by a few broad strips of adhesive plaster, carried completely around the body. Over this, a broad gum-elastic band should be worn, in order to give due support to the whole abdomen. If the child has attained the age of two or three years, a proper truss should be used, such as that worn in this variety of hernia in the adult. If, under this treatment, a radical cure be not effected, the edges of the ring should be transfixed by a stout silver needle, fastened by a ligature, and retained until firm union is obtained. The subcutaneous wire suture might also be tried. No danger would be likely to result from either procedure. If strangulation should occur, and an operation be demanded, opening of the sac must be carefully avoided, lest fatal peritonitis should be provoked.

In the Adult.—In the umbilical hernia in the adult the tumor is usually globular, or pyriform, and, from not being larger originally than the end of the finger, it may, as it increases in age, acquire an enormous volume, extending, perhaps, as low down as the pubes. In corpulent persons it often manifests a disposition to insinuate itself beneath the skin, within the adipose matter, and the consequence is that it sometimes forms hardly any perceptible enlargement, as it does when the subject is emaciated. A hernia in such a state is peculiarly dangerous if it happen to become strangulated, from its liability to be overlooked, and, therefore, mismanaged. An instance of a fatal mistake of this kind occurred, some years ago, in the hands of a medical friend, a man of great intelligence, who never suspected the true nature of the disease until it was revealed by dissection after death. The patient was a married woman, whose abdomen was loaded with an enormous quantity of fat, beneath which a large, strangulated umbilical hernia existed.

An umbilical hernia in the adult generally contains omentum, or omentum and a portion of the colon; sometimes small intestine, but very rarely alone. The stomach and other viscera are occasionally included in it. Many years ago I dissected the body of a woman, the mother of three children, in whom the hernia was composed exclusively of the gravid uterus, near the full period of gestation. The centre of the tumor bore distinct evidence of the remains of the umbilicus. A similar case has been described by Murray. An instance of a double umbilical hernia occasionally occurs. The coverings of the tumor consist of the skin, superficial fascia, and peritoneum, the latter of which, especially in cases of long standing,

is sometimes very thin, or thin at one point and thickened at another. The umbilical ring is generally towards the upper part of the tumor.

The most common causes of this form of rupture are laborious parturition, pregnancy, and habitual straining at stool. Females are much more subject to it than males, and fat persons than lean; it is rarely met with before the age of twenty-five or thirty, or until after the abdomen has become enlarged and pendulous from incessant distention of its walls. Constipation of the bowels, flatulence, colicky pains, nausea, and other evidence of gastro-intestinal disorder are common attendants upon this variety of hernia. An instance in which strangulation of the small bowel occurred in an old hernia of this kind, in consequence of an opening formed in the umbilicus by ulceration, has been reported by Dr. T. L. Ogier, of Charleston, South Carolina.

The diagnosis of umbilical hernia is generally sufficiently easy. When any difficulty arises it is usually due to the existence of a fatty tumor, an instance of which occasionally occurs in the linea alba, where, especially if it is small, it may be mistaken for an omental rupture. Scarpa very candidly confesses that he once committed an error of this kind. A woman was seized with colic and nausea, accompanied with constipation and painful tympanites. A tumor, the size of a large nut, existed just below the umbilicus, on the left side of the middle line. Convinced that it was a strangulated hernia, an operation was performed, when it was ascertained that the tumor was merely a small mass of hard fat.

The means best calculated for the retention of a small umbilical rupture in the adult is a truss with a wooden block, at least two inches in diameter, slightly convex upon its abdominal surface, and secured to an elastic spring, long enough to encircle the body. The ends of the spring should be fastened behind to a broad, oblong pad, six inches in length, and arched transversely, to adapt it the more accurately to the spine. When there is much obesity, or great volume of tumor, the block should be proportionately larger, and the operation of the instrument should be aided by a gum-elastic supporter, which, by taking off the weight of the abdominal viscera, will thus serve to diffuse and equalize their pressure against the abdominal parietes. No truss that does not combine these qualities can be considered, under such circumstances, as of much value; for, although a radical cure can seldom be effected in any case, there is hardly a tumor, however large, inconvenient, or painful, that may not be materially relieved by these means. As to the blocks and pads with a central prominence, until lately so much used in this country, it would be difficult to conceive how they could produce any other than an injurious effect, as their action must inevitably be to separate still farther the edges of the umbilical ring into which the knob projects.

One of the peculiarities of the umbilical hernia in the adult is that, if neglected or mismanaged, it soon becomes irreducible, either from the enlargement of its contents, or from their adhesion to each other and to the inner surface of the sac. Hence, every possible endeavor should be used to prevent this occurrence, or, if this be impracticable, to restrict it within the smallest possible limits by suitable antiphlogistic and retentive means. The existence of tenderness and pain in the tumor, constipation of the bowels, nausea, and general uneasiness in the abdomen, should be attentively watched, and regarded with suspicion. Should the symptoms increase instead of diminishing, blood should be abstracted by the lancet and by leeches, the rectum stimulated by injections, and the belly well fomented with hot water and laudanum. To aid in the removal of plastic matter, small doses of mercury may be used for some time after, and sorbefacients applied to the tumor. If, notwithstanding these precautions, the hernia remains irreducible, or if it was so before the surgeon was consulted, timely measures must be employed for the prevention of its further increase, as well as for its protection against external injury. The most efficient and convenient apparatus for this purpose is a hollow truss, cup-shaped, well padded, and retained in place by a scapulary, or the addition of a gum-elastic supporter. To obviate griping, flatulence, and dyspepsia, a concentrated, easily digestible diet and a soluble state of the bowels should be enjoined.

If strangulation ensues, no time should be lost in employing the taxis, the patient being anesthetized, and placed pretty much in the same position as under similar circumstances in the other varieties of hernia. If the tumor is at all bulky, its contents, after having been drawn away from the umbilical ring, must be pressed

directly upwards, or upwards and backwards, in a direction opposite to that of the protrusion, it being remembered that in all cases of this kind the tendency of the parts is to descend toward the pubes. Should the taxis fail, and the symptoms not be urgent, the effects of a full anodyne and of cold or warm applications may be tried, and often with a prospect of success. When it is remembered how disastrous are most of the operations that are performed for the relief of strangulated umbilical hernia, it is hardly possible to lay too much stress upon the protracted and judicious employment of the taxis. There is a period, of course, when we must desist, or when further efforts of the kind would be improper, but it is not always easy to specify it, and much must, therefore, be left, in every instance, to the judgment of the practitioner.

In performing the operation, an inverted **1**-shaped incision will generally be proper, the vertical limb being carried nearly an inch above the upper extremity of the tumor, directly in the course of the linea alba. Bearing in mind the thinness of the external coverings, particularly in recent cases, the knife is passed, upon a grooved director, successively through the skin and cellulo-fatty matter, down to the hernial sac, which is, if possible, left intact, experience having shown that its division is fraught with the greatest danger, from its liability to be followed by fatal peritonitis. Seeking now for the seat of the stricture, which will usually be found to be at the superior margin of the ring, the knife is conducted upwards upon the finger, and the resisting structure divided to the requisite extent. The protruded parts, being drawn somewhat downwards, to liberate them from their confinement, are next gently replaced into the abdomen, first bowel and then omentum, in the usual manner. Should the constriction, however, be ascertained to be within the sac, then the sac must be opened, care being taken, for the reason already mentioned, to make the incision as small as possible. When the hernia is irreducible, the protruded structures are left, after the division of the stricture, in their extra-abdominal situation.

In the case of Dr. Ogier, above referred to, where the bowel protruded through an opening at the umbilicus, caused by ulcerative action, the edges of the orifice were united by the quilled suture, followed by a complete cure.

VENTRAL, PELVIC, AND DIAPHRAGMATIC HERNIA.

Hernia may occur at other points than those where the natural openings of the abdomen exist, the names by which it is designated having reference to the particular situation of the protruded viscera, as ventral, lumbar, obturator, and ischiatic.

a. Ventral hernia is so called from the fact that it involves the parietes of the belly, which are rendered defective in consequence of a wound, or the accidental separation of some of the muscular and tendinous fibres. It may occur in any part of the walls of the abdomen, but is most common in the middle line, above the umbilicus and in the inferior half of the semilunar line. The tumor, although generally diminutive, is capable of acquiring a large bulk, and has seldom more than three coverings, namely, the skin, superficial fascia, and proper sac. The symptoms and treatment involve nothing peculiar; nor does the operation when strangulation takes place, except that special care should be taken not to injure the epigastric artery, as might happen if the stricture were divided in any other direction than the perpendicular. The sac ought also generally to be left intact, for fear of violent peritonitis.

Pipelet, in the Memoirs of the French Academy of Surgery, has described a variety of ventral hernia under the name of *epigastric*, as the protrusion occurs in the region of the stomach, although no case seems to have ever been observed in which this organ was entirely included in the tumor. The rupture is generally situated a little to the left of the middle line, in a fissure between the straight muscles, and varies in size from an ordinary marble up to that of an orange. Its chief interest arises from the fact that it commonly causes considerable gastric disturbance, as pain, flatulence, and nausea. Its contents nearly always consist of a portion of omentum, or of omentum and of the arch of the colon.

b. Lumbar hernia, a comparatively infrequent occurrence, is situated, as the name implies, in the loins, between the crest of the ilium and the last rib. Coexisting

When, by their long extra-anal sojourn, the parts have become abnormally thickened, indurated, and stiffened, thereby impeding their restoration, great benefit will accrue from leeching, the application of a very weak solution of iodine, punctures, and scarifications. Touching the whole surface of the protruded membrane lightly, every third or fourth day, with a weak solution of nitrate of silver is sometimes highly efficacious. In recent cases, more especially, the tumor sometimes becomes partially strangulated, from the constriction of the sphincter muscles, and then no time must be lost in effecting reduction, the efforts being promoted by the use of chloroform, and the thorough elevation of the nates, the thighs being at the same time widely separated from each other. Gentle but steady pressure being now made upon the tumor, no difficulty will generally be experienced in accomplishing the object; if the resistance, however, is obstinate, it may be promptly overcome by the subcutaneous division of the fibres of the sphincter muscles on each side of the anus. Rude attempts at replacing an inflamed prolapsed bowel are sometimes followed by abscess of the liver, as in a case recorded by Cruveilhier.

Not much is to be expected, in any case, from the use of retentive apparatus, as it can seldom be worn with any comfort either by the young or old, while in many instances it is productive of positive inconvenience and even suffering. Instead of this, it is much better, in both varieties of prolapse, to remove a portion of the mucous membrane, on each side of the anus, with the ligature, in the hope that during the cicatrization the caliber of the tube will diminish sufficiently to prevent relapse. One such operation will ordinarily suffice, but when the protrusion is extensive, it may be necessary to repeat it; not, however, without caution, lest injurious contraction ensue.

In the complete form of the affection, especially when of long standing, a more complicated course is sometimes required, consisting in the excision of some of the cutaneous folds of the ano-gluteal region. Several of these folds are raised at each side of the anus with the forceps, and cut off at their base along with some of the subjacent tissues, and even a few of the muscular fibres, especially if they are much stretched and atrophied. The edges of the wounds are afterwards tacked together by several points of the interrupted suture. It will generally be well to carry the knife as far as the junction of the skin with the mucous membrane. The object of the operation, of course, is to provoke contraction of the anal orifice. When it fails, a V-shaped piece of the anus may be removed at each side, approximation being effected and maintained by suture, very much as in harelip. Some years ago, I assisted Professor T. G. Richardson in such an operation, but, although it was well executed, no appreciable benefit resulted. The patient, a middle-aged woman, had for years labored under an immense prolapse of the lower gut, attended with great and permanent relaxation of the integument and muscles of the anus, which had resisted every mode of treatment that could be devised for its relief.

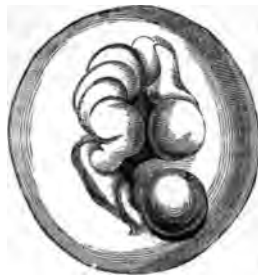
In permanent prolapse of the rectum in elderly subjects, who are adverse to surgical interference, or in whom the use of the knife would be improper, great comfort may be derived from the application of isinglass plaster, a strip from two and a half to three inches in length by nine lines in width being stretched vertically across the anus, so as to afford firm support to the weakened fibres of the sphincter muscles. The plaster, which should consist of rather thick material, is easily applied, and generally retains its hold from one evacuation of the bowel to another. Dr. Abbot, of Boston, by whom this method of treatment was first suggested, speaks of it in the highest terms, and the results of my own experience fully corroborate the truth of his statement.

HEMORRHOIDS.

Of hemorrhoids there are two distinct varieties, differing in their situation, in their structure, and also in regard to the treatment required for their relief. Besides these, there is occasionally a dilated and varicose condition of the hemorrhoidal veins, simulating ordinary piles, and equally productive, at least in many cases, of severe suffering.

The most common variety of this disease is what is called the *external hemorrhoid*, as it is always seated at the verge of the anus. It consists essentially in an extravasation of blood into the cellular tissue of the part, caused by the rupture of a hemorrhoidal vein, the tumor being covered partly by skin and partly by mucous

Fig. 470.



External Hemorrhoids.

membrane. As the effused blood always speedily coagulates, the tumor soon becomes hard, firm, and inelastic, its contents rolling out, after an incision has been practised, as a solid mass, of a dark purple color, and without any admixture of serum. The pouch in which the blood is contained is usually composed, in part, of the ruptured coats of the vein, the remainder being formed, as already stated, by the connecting areolar substance, the cells of which are generally speedily closed by plastic matter. Sometimes, again, the tumor is formed exclusively by a sac-like expansion of the vessel, attended with the solidification of its contents, both there, and for a short distance above the verge of the anus. The latter arrangement, indeed, exists in nearly all cases of external piles; hence,

if an incision be made into such a tumor, and its contents pressed out, no bleeding follows, as there necessarily would if the vein were not effectually occluded by blood and lymph. The appearances of the external pile are well illustrated in fig. 470, from a preparation in my private collection.

It will thus be perceived that this variety of hemorrhoids bears a close resemblance to apoplexy of the parenchymatous organs, and what adds still farther to the similitude is that the effused blood, if not removed by operation, is either entirely absorbed, or, as more commonly happens, a portion of it remains, becoming organized and transformed into a solid, fibroid tumor.

External piles range in size from a pea to that of a pigeon's egg, the most bulky being usually seated at the side of the anus, as it is there not only that the largest hemorrhoidal veins exist, but also that the greatest amount of cellular substance is found, thus admitting more readily of their expansion. In regard to their number, there may be only one, or as many as three, four, or even five, although this is rare. Their color varies with the structure of the external covering, the cutaneous part being usually light, while the mucous part is of a dark or purple aspect, owing to its greater vascularity. Their complexion is always materially heightened by inflammation. An external hemorrhoid is usually very sensitive, the patient complaining of a feeling of weight, distention, and throbbing, which is sure to be increased by the erect posture, by walking, and by whatever has a tendency to cause a flow of blood to the anus and neighboring structures. If, from these and other circumstances, it becomes irritated, the suffering is greatly aggravated, the tumor assuming a dark red appearance, at the same time that it is hot, swollen, and shining, from sero-plastic infiltration of the connecting cellular tissue. If the morbid action is not promptly checked, abscesses may form, attended with enormous tumefaction, and perhaps followed by a fistule. During the discharge of the pus small coagula escape, and as the healing process advances the hemorrhoid disappears, a radical cure taking place.

This variety of tumor sometimes occurs at a very early period, several well-marked cases having fallen under my observation in children under four years of age. Young girls are, I am inclined to believe, more liable to it than boys. After the age of puberty, however, males suffer more frequently than females.

The predisposing *causes* of external hemorrhoids are whatever has a tendency to create congestion, debility, and dilatation of the hemorrhoidal veins; as habitual accumulation of the feces in the rectum, pelvic tumors, tight lacing, venereal excesses, horseback exercise, the constant maintenance of the erect posture, and an unnatural development of these vessels, whether congenital or acquired. The exciting causes are straining at stool, impacted feces, equitation, the pressure of the child's head during parturition, and, in short, whatever is capable of producing distention and rupture of the hemorrhoidal veins.

The external pile may occur alone, or it may coexist with the internal pile, as well as with various other affections, as prolapse, fissure, stricture, carcinoma, and poly-poid growths. Once formed, the disease is extremely liable to reappear from the slightest causes. The history of the case, and a careful inspection of the part, always suffice to establish the diagnosis.

Nothing can be more simple than the *treatment* of an external pile, and yet, for the want of a correct knowledge of its anatomy, hardly any disease is more frequently mismanaged. A simple incision is generally all that is necessary to afford

prompt and permanent relief. The knife being carried through the centre of the swelling, down into the sac, its contents are gently pressed out, when a little attention to rest, and the use of cold applications, will suffice to complete the cure. In general, indeed, the patient is able to go about his business immediately after the operation, all suffering disappearing within a few minutes after the tension has been taken off the tumor. When several hemorrhoids exist, they should all be opened at the same time; and then it will also be more necessary to keep the patient on his couch to guard against an increase of inflammation. It is seldom that the sac refills after it has been evacuated; I have, however, met with several instances where this occurrence took place promptly after the operation, evidently from a want of occlusion of the communicating hemorrhoidal vein. In such an event, further interference may either be postponed, or the tumor, if not much inflamed, may be embraced in a ligature, and the projecting part immediately cut off.

The treatment now described should be adopted in all cases of external hemorrhoids, whatever may be their condition. The presence of a high degree of inflammation is no contraindication, but rather an argument for the practice; for, so long as the effused blood is pent up, it must necessarily be productive of mischief, by keeping up tension and irritation. Besides, as previously stated, it never fails, if it is allowed to remain, to become organized, thus leading ultimately to the formation of a tumor, which is constantly in the patient's way in walking, riding, and defecation. A portion, it is true, is always absorbed, but enough is generally left to cause more or less serious inconvenience for a long time afterwards.

The other variety of pile, usually called the *internal*, occult, or bleeding pile, differs very essentially in its structure from the preceding, being composed of a congeries of arteries and veins, in a varicose condition. The disease, in fact, bears a very close resemblance to an aneurism by anastomosis. The alteration which ultimately gives rise to it begins in the submucous cellular substance, the vessels of which, originally so small as to be scarcely perceptible by the naked eye, gradually enlarge until they form, in many cases, branches of considerable size, tortuous, sacculated, and arranged so as to exhibit an intricate, retiform appearance, as delineated in fig. 471. The venous branches usually predominate, both in number and volume, as well as in their varicose disposition. The walls of both classes of vessels eventually become diseased, being thickened in some places and attenuated in others, either alone or conjoined with softening, induration, or ulceration; and, therefore, liable to give way from the slightest causes under the impulse of their contents. Hence, such tumors are not unfrequently the seat of considerable hemorrhage, both arterial and venous. The tissues which connect the diseased vessels together usually experience a certain degree of hypertrophy, although they rarely lose their softness and pliancy. The covering of the internal hemorrhoid consists simply of the mucous membrane, somewhat thickened, or thickened at one point and attenuated at another, and variously altered in color and consistence. If, therefore, a section be made of such a tumor, it will be found to exhibit a porous appearance, the apertures corresponding with the calibers of the dilated arteries and veins of the part, and the solid structure with the parietes of the vessels and their connecting cellular substance, while the peripheric layer represents the mucous tunic of the bowel.

Internal piles are always situated above the verge of the anus, at a distance varying from a few lines to two inches and a half; in general, they are just above the level of the internal sphincter muscle. When numerous, they are either pretty closely grouped, or they are scattered over a considerable surface, involving, perhaps, the entire circumference of the ano-rectal outlet, as in fig. 472, from a specimen in my cabinet. It is seldom that only one such tumor is met with; most commonly there are not less than two or three,

Fig. 471.



Minute Structure of an Internal Hemorrhoidal Tumor.

Fig. 472.



Internal Hemorrhoids.

and I have repeatedly seen as many as five, six, and even seven, varying from the size of a pea up to that of a large marble, which such growths rarely exceed, unless they are solitary or of long standing, when they may be as large as a pullet's egg.

Internal hemorrhoids are ordinarily of a florid complexion, but when they are irritated or inflamed, as they necessarily must be when they are prolapsed and com-

pressed by the sphincter muscles, they assume a dark bluish, purple, or livid aspect, owing to the congested and stagnant condition of their vessels. The more common appearances of these tumors, as displayed during defecation, are exhibited in fig. 473, from Ashton.

Tumors of this kind are always soft, spongy, and erectile, diminishing under pressure, but immediately regaining their former volume when the pressure is removed. They are generally of a globular shape, and attached by a broad base; sometimes, however, they are pyriform, and in rare cases they present themselves as vertical semicylindrical ridges, upwards of an inch in length by several lines in diameter, as in fig. 472.

The surface of the internal hemorrhoid, originally smooth, often becomes roughened by deposits of lymph, or by the enlargement of the mucous villi. Ulcers are occasionally seen upon it, generally very small and superficial, but sometimes of considerable extent, and so deep as to penetrate the tumor, and cause more or less hemorrhage, thus constituting what is called a bleeding pile.

The internal hemorrhoid is seldom seen before the age of puberty; but after that period the affection is exceedingly common, in both sexes, in different classes of society, and in different occupations. Persons who lead a



Protruding Hemorrhoid.

sedentary life, with a gross habit of body, or who are constantly suffering from dyspepsia, or who labor habitually under constipation of the bowels, are particularly prone to the disease. Horseback exercise, the standing posture, diarrhoea, dysentery, worms, rectal tumors, drastic cathartics, and, in short, whatever produces frequent and severe straining, are so many predisposing causes of internal hemorrhoids. To the same category belong the different kinds of mechanical obstruction to the passage of the urine, as stricture of the urethra, enlargement of the prostate gland, and stone in the bladder; also the pressure of pelvic tumors, and of the gravid uterus. Under the influence of these and other causes the vessels of the submucous coat of the ano-rectal region are gradually converted into large varicose tubes, which, as they increase in volume, lift up the lining membrane, forming thus a soft, vascular, and erectile tumor.

Internal piles, unless large or numerous, are not productive of much suffering, the chief symptoms being a sense of weight and stuffing in the ano-rectal region; under opposite circumstances, however, there are frequently severe pain and throbbing, sometimes extending down along the sciatic nerve, difficult defecation and spasm of the sphincter muscles, with more or less prolapse of the anus, and also of the tumors themselves, especially when the patient is at the water closet. At such times the parts being compressed and congested, the suffering is often so exquisite as to induce free perspiration and even partial syncope; from the same causes pretty copious hemorrhage sometimes results, the blood either oozing out at various points, as from the surface of a sponge, or spirting out at one particular spot, corresponding with the orifice of an ulcerated or ruptured artery. The protruded parts being replaced, as they generally have to be, with the fingers, the distress gradually subsides, the patient remaining comparatively comfortable until he is again obliged to relieve his bowels, when there is an immediate recurrence of all the previous symptoms. Thus, the disease may progrees for many years, the patient being now better, now worse; liable to frequent exacerbations and remissions; generally capable of attending to business, but rarely, if ever, entirely free from suffering for a single day; more comfortable at night, while recumbent, and worse after exercise, a hearty meal, a glass of wine, severe mental emotion, or sexual indulgence. Unless there is constantly recurring hemorrhage, it is astonishing how little

the general health is often impaired. I have known repeated instances in which, although the local distress was very severe, entailing a certain amount of pain daily for many years, the individuals were able not only to attend closely to their occupation, but absolutely thrived under the disease, being robust and well-conditioned in every respect. Under such circumstances, it would really seem as if the hemorrhoidal irritation served to ward off disease from other and more important organs.

The quantity of blood lost during the progress of internal hemorrhoids is sometimes almost incredible. Cases have been recorded in which it is said to have amounted daily, for many years, to two, three, five, six, and even eight ounces. Doubtless some of these cases have been exaggerated, but that many of them have been correctly reported is altogether probable. I have myself seen instances where the daily loss thus sustained had produced the most frightful debility. Excessive pallor of the countenance, vertigo, indistinctness of vision, ringing noises in the ears, palpitation of the heart, coldness of the extremities, indigestion, emaciation, and a tendency to dropsical effusions, are the most prominent symptoms of this occurrence. In the female, this species of hemorrhage is sometimes vicarious of the menses. It is generally most abundant during defecation, or immediately after, especially if the parts have suffered protracted protrusion.

Internal piles are sometimes seized with gangrene, but such an event can only happen when the tumors, prolapsed by frequent and excessive straining or inordinate relaxation of the parts, are firmly grasped by the sphincter muscles, the effect being similar to that of a ligature. The tumors then become livid, swollen, and exquisitely painful, and in a few days drop off, the patient, in the mean time, suffering much constitutional disturbance.

The diagnosis of this variety of pile is readily determined by the history of the case, by inspection, and by digital examination. The speculum can seldom be used to advantage, unless the patient is under the influence of an anæsthetic. If the disease has made considerable progress, the tumors may usually be easily brought down by requesting the patient to strain, as if at stool, while sitting on the chamber, or, what is better, in a tub of warm water. Their globular form, florid, bluish, or livid color, soft feel, and intimate attachment to the ano-rectal mucous membrane, will at once establish their identity, and serve to distinguish them from other diseases of this region. If the swellings cannot be seen, then the finger takes the place of the eye, being carried about gently, but effectually, over every portion of the bowel within its reach; aided, if need be, by the speculum.

The treatment of internal piles is palliative and radical. The former, which is often alone available, on account of the timidity of the patient, resolves itself chiefly into measures calculated to improve the condition of the digestive organs, to regulate the bowels, and to allay local irritation. It is surprising how much good may frequently be done in this disease by attention to the diet and secretions, followed occasionally by a mild aperient, as blue mass and rhubarb, or sulphur and jalap. All drastic purgatives are, of course, inadmissible, especially such as have a tendency to act specifically upon the lower bowel. The diet must be plain, non-stimulant, and concentrated; wine, spirits, coffee, and strong tea are to be avoided. After the secretions have been duly attended to, from ten to fifteen drops of balsam of copaiba, in the form of emulsion, may be given three times a day, combined, if necessary, with a little black drop, especially if there be a tendency to diarrhœa. In the milder varieties of the malady, I know of no internal remedy superior to this in affording relief, although of its mode of action it is impossible to offer any satisfactory or even plausible explanation. With Ward's paste, as it is termed—a preparation consisting essentially of black pepper—so much extolled by British practitioners in the treatment of internal piles, my experience is very limited, but what I have seen of its effects does not justify the encomiums lavished upon it. When the patient is in need of a tonic, the most suitable remedies will be sulphate of iron and quinine, particularly when there is an enemic state of the system. Solubility of the bowels is best maintained by the daily use of a cold water enema, evacuation being effected habitually in the recumbent posture.

Locally, the most grateful applications are cold water, in the form of baths and enemata; mildly astringent injections, as a weak solution of acetate of lead, tannic acid, or alum, either alone or conjoined with an anodyne; leeching, if there be a great sense of weight and fullness in the parts; and emollient poultices, or the warm

water-dressing, if the piles are protruded, inflamed and tender. In the latter case, the gentle application of the solid nitrate of silver to the inflamed surface often proves highly beneficial. It need hardly be added that replacement of the tumors should always be promptly effected, whenever this is practicable, the efforts being facilitated, if necessary, by topical bleeding, either by scarification or leeching, and other means. An ointment composed of equal parts of sulphur and honey has long been a popular remedy in the treatment of internal hemorrhoids, and may no doubt occasionally be used beneficially, especially in the milder forms of the affection. When there is much spasm of the sphincters, belladonna ointment is worthy of trial, although I have rarely derived much advantage from it. In the hemorrhagic variety of piles, free use must be made of strongly astringent injections, as subsulphate of iron, alum, sugar of lead, or Goulard's extract, brought, if possible, in immediate contact with the affected surface; aided, in all cases where the bleeding is profuse, by liberal doses of opium by the mouth in order to tranquilize the heart's action.

For the radical cure of internal piles, the proper operation is ligation, performed in such a manner as to cause prompt and effectual strangulation. The patient being under chloroform, the tumor, after being properly exposed, is seized with a tenaculum, or volsella, and tied with a stout, well waxed thread of saddler's silk, secured with a double knot, with the ends cut close to the surface. If the hemorrhoids are numerous, the largest only are selected for operation, the cure of the remainder being intrusted to the resulting inflammation, which generally affords a sufficiency of plastic matter to occlude the dilated and hypertrophied vessels. Should the cure be imperfect, the reculant tumors are similarly dealt with at a future and not distant period. Such a procedure is far better than too much interference at one time, which might not be free from risk. If the hemorrhoid has an unusually broad attachment, it may be necessary to transfix its base with a large curved needle, armed with a double ligature, each of which should then be tied around the corresponding side of the morbid growth. The operation being over, the patient takes a full anodyne, to allay pain and paralyze the bowels, and remains in bed for five or six days—the period of the detachment of the ligatures—or until the parts are sufficiently comfortable to enable him to sit up or move about the room. No aperient medicine is administered until there is a positive necessity for its use, as indicated by the patient's feelings, and then only the mildest kind, as a dose of citrate of magnesia, to liquify the feces. If the parts become painful after the operation, they may be fomented, poulticed, and even leeches, or cautiously scarified, especially if, as sometimes happens, they are infiltrated with sero-plastic matter. The bladder, if need be, is relieved with the catheter. The terrible spasm and tenesmus which sometimes supervene are best controlled by means of a laudanum enema or an opiate suppository. They are most common, according to my observation, in nervous, irritable women, long the subjects of hemorrhoids or hemorrhoids and uterine disease. To prevent these sufferings some surgeons stretch the sphincter muscles forcibly as a preliminary measure, as in the operation for anal fissure. During convalescence, as well as for a long time after, the rectum should be well washed out twice a day with cold water, or some cold demulcent fluid.

The operation now described is generally as simple of execution as it is free from danger and certain in its results. Considering these circumstances, it is surprising that any surgeon should ever think of excision as a remedy for the radical cure of this complaint. To cut off an erectile tumor, composed, as it is, of numerous dilated and tortuous vessels, would certainly be a most dangerous undertaking, since it could not fail to be followed by severe hemorrhage, always difficult to arrest, and sometimes fatal. Whoever has studied the memorable cases of excision of internal hemorrhoids by Dupuytren and Cooper, will not be likely ever to repeat an operation which was attended with such disastrous results in the hands of these great men.

Although ligation of these tumors is generally entirely free from danger, yet, now and then, a case occurs where it causes severe pain and inflammation, erysipelas or even death by pyemia, as in an instance under my observation in a young gentleman, otherwise in good health, who perished on the eighth day after the operation, the dissection revealing the existence of an immense number of small metastatic abscesses in the cellular tissue of the mesorectum. The ligatures were detached about the usual time, and the parts themselves exhibited nothing uncommon. Fatal

from this cause have been reported by Cooper, Brodie, Mr. Henry Lee, and . It should be added, however, in justice to this mode of treatment, that methods have occasionally been followed by similar results. Thus, Nélaton, a young man, the subject of piles, from the application of the actual cautery; several cases are known where death was caused by the use of Vienna paste. Mishaps, which are as distressing as they are to be deplored, should admonish to interfere with hemorrhoids without due preparation of the system. Especially should operative interference be refrained from during the prevalence of the disease.

Ligation of hemorrhoidal tumors is occasionally followed by tetanus. Mr. Lane, of London, in 1861, reported not less than four fatal cases of this kind, consequent upon this operation, two of them having occurred in his own case, and two in that of Mr. Gowland. Dr. Ashhurst refers to two similar cases having occurred at the Episcopal Hospital, of this city, in the wards of his patients.

The *écraseur* is occasionally used for removing internal piles. It does its work promptly and effectually, but the operation cannot be borne without the aid of anesthesia. Besides, it is sometimes followed by serious stricture of the rectum, and in some instances have occurred in which the patient perished from hemorrhage.

Henry Smith, of London, prefers seizing the tumor with a clamp, fig. 474, the ends of which are covered with ivory, cutting it off, and then searing the surface

Fig. 474.



Smith's Hemorrhoidal Clamp.

by the actual cautery, on the ground that it is a safer, a less painful, and a quicker method than that by the ligature, and he asserts that he has performed it nearly one hundred times without the slightest mishap. Most of his patients walked about by the end of the first week, and in a majority of the cases the suffering consequent upon the operation was inconsiderable.

He has occasionally used nitric acid for destroying internal piles, but with results insufficiently gratifying to induce me to recommend its adoption as a means of cure, being satisfied that, while it is more difficult of application and produces more pain and inflammation than the ligature, it is much less certain in its effects and more liable to be followed by relapse. Besides, the remedy is not free from danger, several cases having occurred in which it proved fatal. The treatment, which is adapted only to the milder forms of piles, with a broad base, was originally suggested by the late Mr. Houston, of Dublin, and has been strongly advocated by several recent writers, among others, by Mr. Henry Lee, of London. The acid, the strongest and purest of its kind, is applied by means of a soft piece of lint, with a flat extremity, directly to the diseased surface, previously brought out by straining, and well wiped, care being taken not to allow any to come in contact with the skin. The part touched, as well as the adjacent mucous membrane, is then carefully anointed with lard, and the bowel restored to its proper position. Several applications are sometimes necessary to effect a permanent cure.

VARICOSE HEMORRHOIDAL VEINS.

Enlargement of the hemorrhoidal veins is met with chiefly in elderly persons, in connection with a varicose state of the veins of the lower extremities and of the abdominal cord. In its worst forms it always implicates a number of vessels, which are not only much dilated, but very tortuous, convoluted, and knotty, similar to what is so frequently noticed in the saphenous vein and its branches. The varicose is always most conspicuous in the ano-rectal region, but cases occur where it extends nearly as high up as the terminations of these vessels. The enlarged vessels

can easily be felt at each side of the anus, both through the skin and mucous membrane, as firm, rigid cords, with, perhaps, here and there, a phlebolite. Not unfrequently, indeed, they may readily be distinguished by their bluish appearance alone. When it is remembered that these vessels are destitute of valves, and that they are constantly subjected to motion and pressure, it is not surprising that they should become diseased, and ultimately varicose.

Varicose enlargement of the hemorrhoidal veins should not be confounded with hemorrhoidal tumors, which it so often accompanies, as it is very different from that affection. It is characterized by a sensation of weight and fullness in the ano-pelvic region, by vague, uneasy feelings in the perineum, sacrum, and loins, and by smarting, burning, or stinging pains during defecation, and for a short time after. On inserting the forefinger into the bowel, and applying the thumb to the surface of the anus, the affected vessels may easily be felt like so many separate cords, or like scattered earth worms. The general health is not necessarily impaired, although it is often deranged, more frequently, perhaps, as a cause than as an effect of the complaint.

Few surgeons, I imagine, would be found bold enough to attempt the obliteration of these vessels with the ligature, and yet such an operation might not, perhaps, involve any greater risk than the tying of a number of large hemorrhoidal tumors. When the disease is a source of constant suffering, linear eschars might be made over a few of the largest veins by means of the Vienna paste, a procedure which may be regarded as perfectly safe, judging from the experience we have of this treatment in varicose enlargement of the veins of the leg. Much may be done in such a case, in the way of palliation, by attention to the bowels and diet, by an avoidance of the exciting causes of the disease, by cold enemata, and by frequent ablutions with soap and water.

ANAL TUMORS.

Pendulous tumors, frequently the result of external hemorrhoids, form around the anus, just at its verge, or at the junction of the mucous and cutaneous surfaces. They are generally soft, irregularly globular, or pear-like in shape, smooth, or rough, and of a solid, fibroid structure. Occasionally, however, they are composed of a spongy, erectile substance, not unlike that of the cavernous body of the penis, and, therefore, liable to bleed after excision. I believe that this form of tumor is more common than is usually supposed, inasmuch as a number of well-marked examples of it have fallen under my observation. Its vessels are apparently merely prolongations of the smaller hemorrhoidal veins, in a state of dilatation and varicosity, and closely invested by rather dense cellular substance. In size, such an excrescence may equal the end of the little finger; its color usually resembles that of the skin, or the mucocutaneous tissues, to which it is attached; it is sometimes solitary, but more frequently multiple. When these growths are very numerous, they may form a complete chaplet around the anus, causing much trouble in walking and defecation. Venereal warts and tubercles also occur in this situation, both in children and in adults, the former as an effect of local, the latter of constitutional, contamination. Finally, an instance of the true sebaceous tumor is occasionally seen here. It is easily recognized by its indolent character, doughy consistence, and pale color.

If troublesome, these circumanal growths may be removed with the knife, or snipped off with the scissors. The erectile tumor should, however, always be tied, on account of its liability to hemorrhage; or, if excision has been practised, and bleeding ensue, ligation must follow the knife, the edges of the wound being raised with the tenaculum, and firmly tied. In a case of this kind, in a patient of Dr. O'Reilly, I was finally compelled, after unavailing efforts with other means, to adopt this measure, using both the twisted and the interrupted suture, profuse bleeding having come on within an hour after I had cut off five or six of these excrescences. Venereal warts may be excised, or destroyed with chromic acid, dry lint being interposed in the intervals of the application. Syphilitic tubercles require the ordinary topical and constitutional treatment. Sebaceous tumors are extirpated.

POLYPS OF THE RECTUM.

Polyps of the rectum are uncommon. Children under twelve years of age are most liable to them, but they are also met with in adults, and sometimes, although very rarely, in elderly persons. In regard to their structure, they are, like polyps of the nose and uterus, divisible into two classes, the gelatinoid or adenoid and fibroid. The former, of far more frequent occurrence than the latter, are made up of œdematous connective tissue interspersed with very numerous enlarged glands, invested by cylindrical epithelium, liable to the cystic transformation, and capable of assuming a papillary appearance under protracted exposure to the air. As to the circumstances which determine their development, nothing whatever is known. They are all of tardy growth, free from malignancy, prone to hemorrhage, and liable to protrude during defecation. In their volume they vary from a filbert to that of a hen's egg, their shape being, for the most part, somewhat pyriform, ovoidal, or globular, while their attachment is usually effected through the medium of a slender pedicle, which is sometimes of extraordinary length. In the case of an Irishman, on whom I operated, some years ago, the polyp, which was of the gelatinoid variety, and not larger than an ordinary marble, had a pedicle upwards of four inches in length, hardly as thick as an ordinary stalk of wheat. Occasionally, on the other hand, the pedicle is very short, not exceeding a few lines. Authors speak of sarcomatous polyps of the rectum, with a tendency ultimately to take on malignant action; of this form of the disease I have never seen an instance, and am certain that it must be very rare. The distance at which these morbid growths are situated from the anus varies from two to six inches, the average being about three inches or three inches and a half. It is seldom that they are multiple. The adjoining cuts afford a good idea of the external and internal characters of a celluloso-vascular polyp removed from a child three years old. Fig. 475 shows its

Fig. 475.



Polyp of the Rectum; External Appearance.

Fig. 476.



Polyp of the Rectum, showing its Internal Structure.

shape, which, in this case, was reniform, and fig. 476 the internal structure. The tumor had throughout a cellulated appearance, like the surface of a sponge, the cavities in the recent state being occupied by thick mucus.

Persons who labor under rectal polyps generally experience a sense of weight and uneasiness in the lower part of the pelvis, with a frequent desire to relieve themselves, and more or less straining during defecation. The feces are usually somewhat flattened, and there is almost always an abundant discharge of mucus, of a glairy, reddish appearance, not unlike thin currant jelly. When the tumor is situated near the anus, or when it has an uncommonly long pedicle, it is apt to protrude during defecation, and to be compressed by the sphincter muscles. At such times, too, it is liable to bleed, although this also sometimes occurs when it remains undisturbed, especially if it be very vascular. In children, indeed, the loss of blood from this source is occasionally quite considerable. A tumor of this kind may be detached by the forcible contraction of the bowel, or it may slough off from the pressure exerted upon it by the sphincter muscles. The general health is commonly unimpaired.

A polyp of the rectum is usually easy of recognition. Its tardy growth, its floating nature, its occasional protrusion at the anus, and the functional disturbance which it causes in the bowel, together with the tender age of the patient, and the almost invariable existence of hemorrhage, are generally sufficiently characteristic. When any doubt obtains, a thorough digital examination will promptly dispel it. The affections which are most liable to be mistaken for it are stricture, hemorrhoids, and prolapse. In the child, the existence of the disease should always be suspected when there is frequent recurring hemorrhage from the bowel.

The only remedy is removal by ligature or torsion. If the tumor is small, and situated just above the verge of the anus, it may be seized with a pair of long, slender forceps, and twisted upon its axis until it drops off, the procedure being conducted in the same manner as in the removal of a nasal polyp; but, under opposite circumstances, or when the growth is very vascular, the safer plan is to tie it, and let it slough off. Finally, when this is impracticable on account of the great height of the tumor, it may readily be destroyed by crushing or strangulation by means of the *écraseur*. The objection to excision is its liability to hemorrhage, which is sometimes so great as to endanger life, and which it might be difficult to arrest, especially when the tumor is seated at a considerable distance from the anus.

PAPILLARY TUMORS.

This is a form of soft tumor of the mucous membrane of the rectum, similar to what is met with in the vesical trigone, and attended with the same local symptoms as polypoid growths, from which, however, it may readily be distinguished by its physical and microscopical appearances. Originally described by Rokitsansky under the name of villous cancer, although it is not, as he supposes, of a malignant nature, the growth is occasionally observed in children, but is most common in elderly subjects, in whom it may exceed the volume of a hen's egg. It consists mainly of elongated villi, reposing upon a broad body, covered by one or more layers of cylindrical epithelium, and extremely vascular, the veins being much enlarged and varicose. Such a growth causes a most distressing sense of fullness in the bowel, as if it were obstructed by a foreign body; and is liable to copious hemorrhage, which sometimes seriously undermines the vital powers. The proper remedy is extirpation, or strangulation with a double ligature.

STRICTURE OF THE RECTUM AND ANUS.

It is difficult to believe that simple stricture of the rectum, such as is so often witnessed in the urethra and other mucous canals, is as common as is generally supposed. My conviction is that it is one of those affections which are much more frequently described than observed. I have certainly very rarely met with it, nearly all the cases of stricture of the lower bowel that have come under my notice having been of a carcinomatous nature.

The most common seat of the disease is from two and a half to three and a half inches above the verge of the anus, or easily within reach of the index-finger. Affecting

Fig. 477.



Stricture of the Rectum.

generally only a portion of the tube, it sometimes reaches around its entire circumference, as in fig. 477, its vertical extent being seldom less than twelve, fifteen, or eighteen lines. The degree of its encroachment upon the caliber of the gut varies from the slightest diminution to almost complete obliteration, the orifice of the stricture being sometimes scarcely large enough to admit of the passage of a goose-quill. The immediate cause of the disease is an effusion of plastic matter into the submucous cellular tissue, the other tunics retaining their integrity, or, at all events, experiencing only a slight change of consistence. This substance soon becomes organized, and gradually assumes a dense, fibrous character, creaking under the knife, and exhibiting a grayish or bluish-white appearance. The tendency of the disease is to extend inwards towards the caliber of the tube, so as to encroach upon the mucous membrane, which, although it may long retain its integrity,

finally yields to the morbid action, becoming adherent to the subjacent parts, and at length ulcerated at different points. The period at which this occurs varies from several months to as many years.

It is not always, or perhaps even generally, possible to trace this disease to any particular cause. In the very few cases that have fallen under my observation, no clue whatever could be obtained as to its origin. It is not unlikely that it may be

produced by an ulcer, or, rather, by the contraction consequent upon the cicatrization of an ulcer; by inflammation arising from the lodgment of a foreign body; by the use of drastic purgatives and irritating injections; and, finally, by the application of the actual cautery, different acids, or hot water. The disease is most common in adults; and a belief prevails that women are oftener affected with it than men.

Organic stricture of the rectum manifests itself by the usual symptoms of alvine obstruction, attended with a frequent desire to go to stool, great straining and bearing down during defecation, and a flattened, ribbon-like shape of the excrement, when this is solid, or a remarkably forcible ejection of it when it is fluid. As the contraction progresses, the suffering increases; the bowels are habitually distended with gas and feces; colicky pains are often present; the appetite and digestion are impaired; the countenance becomes wan and sallow; the mind is despondent and filled with evil forebodings; the flesh wastes; the strength declines; and the surface is easily impressed by atmospheric vicissitudes. Finally, ulceration sets in, greatly aggravating the local and constitutional distress, and death, at length, probably after years of suffering, closes the scene.

The diagnosis of stricture of the rectum is seldom difficult. The diseases with which it is most liable to be confounded are carcinoma, ulceration, fissure, and hemorrhoids. From these it may, however, generally be readily distinguished by its history and by a thorough exploration with the finger and the speculum. Carcinoma is usually rapid in its march, and impresses itself at an early period, in an unmistakable manner, upon the constitution. Fissure is characteristically painful.

A syphilitic stricture is occasionally met with in the lower bowel, caused not by any constitutional taint, but by direct inoculation with chancrous matter. The affection, which is much more common in women than in men, essentially consists in a deposit of plastic substance in the submucous cellular tissue. The obstruction, generally situated just above the sphincter muscle, varies in extent from a few lines to nearly half an inch, and is often so tight as hardly to admit of the passage of the finger. The parts at and around the stricture are inflamed, highly sensitive, thickened, ulcerated, and bathed with pus, the quantity of which is often very copious. The general health is greatly impaired; the patient is wan and sallow, much emaciated, dyspeptic, despondent, and excessively irritable. The diagnosis is established by the history of the case, the unusually low situation of the obstruction, and the existence of cicatrices upon the perineum and anus, the effects of former chancres.

The *treatment* is regulated by the same principles as in stricture of the urethra, an attempt being made to induce the absorbents to remove the plastic matter, the cause of the obstruction, by the use of bougies of successively increasing diameters. If much irritation, with inflammatory tendency, exist, a few days are spent in the employment of soothing measures, in order to render the parts more tolerant of the requisite manipulation. A small sized bougie, of gum-elastic, pewter, or sole-leather, well oiled and warmed, is carefully introduced into the stricture, where it is retained from two to five minutes, when it is withdrawn, to be again inserted at the end of forty-eight hours, to remain a similar, longer, or shorter time, according to the effect produced, it being constantly borne in mind that the object is not to excite, but to reduce, action, and to stimulate gently the absorbent vessels. After the first week, a larger instrument is used, now, perhaps, once a day, then a still larger one, and so on, until the tube has been restored to its original capacity; a circumstance, however, rarely to be expected in any case, for there is no disease more likely to prove troublesome and rebellious. When the more common bougies are not at hand, or are not borne, use may be made of a wax, tallow, or spermaceti candle. The intervals of the treatment are occupied in attention to diet and rest, the use of cooling enemata, and various other means calculated to prevent capillary excitement in the part. When the stricture is very firm, and almost impermeable, it has been proposed to notch it at four opposite points, to facilitate the passage of fecal matter and the bougie; and such a procedure is sufficiently plausible to justify its adoption, notwithstanding what has been alleged to the contrary. The surgeon often incises strictures of the urethra, and why should the same principle of treatment not be applied to strictures of the rectum and anus? In contraction of the latter, the operation has repeatedly been followed, in my hands, by great, although not permanent, relief. When the case is utterly hopeless, life may, perhaps, be prolonged by the establishment of an artificial anus in the lumbar region, provided the patient is willing to submit to so disgusting a procedure.

The syphilitic form of stricture of the rectum, or of the rectum and anus, must be treated with astringent and anodyne enemata, dilatation with the bougie, and cautious incisions. The general health is amended by tonics, a generous diet, and nutritious drinks. Mercury and iodide of potassium are of no avail.

CARCINOMA OF THE ANUS AND RECTUM.

Carcinoma of the anus and rectum may exist as a primary disease, or as a propagation from the adjacent parts, as the uterus and vagina, or the pelvic lymphatic glands. The most common form in which it appears is epithelioma, occurring either as an infiltration in the connecting cellular substance, or as a tumor of variable size and shape, and of the consistence which ordinarily appertains to cancerous disease in other situations. Of scirrhus, encephaloid, and colloid of the ano-rectal region very little is known, as they have been noticed only in a few instances. The same remark is strictly applicable to melanosis, of which I have myself witnessed only one example. The patient, a man fifty-eight years old, labored under the same disease in nearly all the principal organs of the body, and died, after an illness of upwards of twelve months, in a state of the utmost emaciation. His principal symptoms, as it respected the anus and bowel, were, frequent discharges of muco-purulent matter, often streaked with blood, diarrhoea, griping, tenesmus, flatulence, and, at length, total loss of power in the sphincter muscles. Several black tumors, hard, irregular in shape, and about the size of small grapes, existed at the verge of the anus; and the finger, carried into the rectum, readily came in contact with a hard cancerous mass, which, on dissection, was found to consist of a mixture of scirrhus and melanosis. The prostate gland was somewhat enlarged, and the bladder had evinced great impatience of its contents during the last five or six months.

Epithelioma of the ano-rectal region is most common in elderly subjects, but I have repeatedly observed it in young adults, and a case has been reported of ulcerated carcinoma of the rectum in a child twelve years of age. One of the very worst examples of carcinoma of the anus, as it respected the rapidity and extent of the malady, that I have ever witnessed, occurred in a man scarcely twenty-two years old. When I first saw him the disease had already attained an extraordinary development, and was attended with great contraction of the anus. My opinion is that epithelioma in both these localities is much more common in young persons than is generally supposed. It is not known what influence, if any, sex exerts upon the production of primary carcinoma here; the prevalent belief is that it is most frequent in the female, but this is opposed to my experience, which has supplied me with a much larger number of cases in the male. Secondary carcinoma, on the contrary, is most common in women, owing to their great liability to carcinoma of the uterus, and the remarkable facility with which the malady, when it occurs here, extends to the vagina, anus, and rectum.

The ordinary site of the disease is at a height of two and a half to three inches from the verge of the anus, or at a point that is generally readily accessible by the finger. Examples, however, occur where it is located further up, or lower down. In the latter case, the malady sometimes coexists with epithelioma of the anus. The most common form in which the heterologous matter exhibits itself in the rectum is the tubercoid, the nodules varying in size from a pea up to that of a pullet's egg, and in consistence from hard cheese to that of fibro-cartilage, their color being usually florid, grayish, or light drab. When the deposit is large, it may involve the whole circumference of the cylinder. It is generally supposed that the posterior portion of the tube is more prone to suffer than the anterior or lateral, but this is very questionable. When the morbid substance occurs as an infiltration in the wall of the rectum, it always exists more conspicuously in the submucous cellular tissue, which has a dense, gristly appearance, intersected by bluish bands, which give the parts an alveolar structure, similar to that of carcinoma of the stomach and œsophagus. When the disease is situated at the anus, it always observes the tuberciform character, and is generally attended with extraordinary hardness. In whatever form it occurs, or whichever of these parts it affects, it is sure, in time, to encroach very seriously upon the caliber of the tube, and finally even to lead to such a degree of occlusion as to prevent effectually the discharge of fecal matter. I have seen numerous cases where the opening was hardly large enough to admit the point of the little finger. The tube above the seat of the obstruction may retain its

natural size, or be somewhat dilated. The period which elapses from the first appearance of the disease to its ultimate termination varies, on an average, from one to two years. As a general rule, epithelioma of the rectum will be found to destroy life sooner, by several months, than epithelioma of the anus.

The *symptoms* of carcinoma of the ano-rectal region are, at first, often obscure, being such, mainly, as attend some of the other affections already described. As the disease, however, progresses it acts not only obstructingly, but gives rise to sharp, lancinating pains, extending into the thighs, nates, perineum, and sacrum, and accompanied with a sense of weight and pressure low down in the pelvis. Defecation is gradually impeded; the patient is obliged to strain a great deal at stool, the calls to which are often unnaturally frequent; and the feces are passed in a flattened, ribbon-like form, instead of being cylindrical, as in the natural state. Very often the only substance evacuated is a thick, glairy mucus, perhaps streaked with blood, or blood and pus, which are liable to be poured out in large quantity, and to escape almost incessantly, thus compelling the sufferer to wear a cloth to keep himself clean and comfortable. The bladder is usually rendered irritable, even at an early period, especially when the disease is located at the anterior wall of the rectum, or the fore-part of the anus; the bowels are habitually distended with feces and gas; the general health gradually fails; the emaciation steadily progresses; and the countenance assumes the peculiar pallid aspect so characteristic of the carcinomatous cachexia.

When the disease, whether seated in the anus or rectum, is fully established, the patient finds it extremely difficult, if not impossible, to sit upright upon his chair. In general, he is obliged to support himself upon one of his nates, or alternately upon the one and the other. In a case which I recently saw along with Professor Pancoast, the patient, a lady, forty-three years of age, affected with epithelioma of the rectum of about sixteen months' standing, was nearly constantly compelled, in order to make herself comfortable, to sit with her head bent forwards over her knees. At night she found great relief by lying with her hands spread out under the buttocks.

The *diagnosis* is generally sufficiently simple, especially after the disease has made some progress. The peculiar character of the pain, the indurated condition of the parts, the gradual contraction of the caliber of the tube, the obstruction to defecation, the abundant mucous or muco-puriform secretion, and its involuntary escape at the anus, the constant distention of the bowels, the flattened character of the feces, and the difficulty of introducing fluids or solids into the rectum, or through the anus, together with the progressive emaciation and failure of the general health, are always unmistakable evidences of the nature of the malady. In carcinoma, the rectum never descends as it does in prolapse and in hemorrhoids; no openings exist around the anus, as in fistule, or, at any rate, very seldom; and there is not that severe spasmodic pain during defecation and for some time after that attends fissure of the anus. Besides, in all these affections, which are more liable to simulate carcinoma than any others, a digital examination may usually be made with comparative ease, on account of the more yielding nature of the parts. Polypoid growths, enlargement of the prostate gland, a retroverted uterus, and the presence of a pessary, are always easily detected by the finger.

Care should be taken not to mistake an enlargement of the lymphatic glands of the pelvis for this affection. These glands are liable, from various causes, as simple ulceration of the anus and rectum, and disease of the bladder, vagina, and uterus, to increase in bulk, so that they may readily be felt as hard, nodular masses through the bowel, and might thus lead to the idea of the existence of epithelioma.

The *treatment* must be conducted upon the same general principles as in carcinoma in other situations. Palliation being all that is to be hoped for in any case, the measures must be chiefly of a soothing and detergent character, consisting of enemata of tepid water, or of tepid water and olive oil, to insure cleanliness and patency of the lower bowel, of frequent ablutions when the disease is external, or when there is much discharge, and of anodyne suppositories, or opiate injections to allay pain and spasm. Fœtor is best relieved with weak lotions and enemata of permanganate of potassa. When there is much heat in the parts, attended with a sense of weight, leeches and the warm water-dressing, simple or medicated, will prove beneficial. The bowels are evacuated in the recumbent position; all sexual excitement is avoided; and the general health is carefully watched and superintended, the food being non-stimulant, concentrated, and nutritious. In the latter stages,

tonics and alcoholic drinks will be necessary, with the internal use of morphia, soda, and carminatives, to calm and soothe the stomach and bowels.

The employment of the bougie in the treatment of carcinomatous affections of the anus and rectum is of doubtful utility, if not decidedly prejudicial. During their earlier stages, and especially in cases attended with inordinate coarctation, while ulceration is not yet impending, the cautious passage of such an instrument, every third or fourth day, may be productive of some benefit in widening the tube, and thus facilitating the evacuation of its contents; but beyond this no advantage is to be anticipated, while its more frequent use could hardly fail to be a source of irritation and mischief. A gum-elastic bougie, well oiled, and retained for five or ten minutes within the constricted part, would be the most eligible instrument.

Excision is not only a dangerous procedure, but seldom affords more than temporary relief from pain and fecal obstruction. When the anus is involved, the operation must, of course, include the sphincter muscles, thereby depriving the patient of the power of controlling his passages, and the same result will be sure to follow, sooner or later, excision of a portion of the rectum, to say nothing, in the latter case, of the immediate risk to life from hemorrhage, peritonitis, and phlebitis.

Professor Billroth, of Vienna, in 1868 informed me that he had excised the anus and lower portion of the rectum upwards of a dozen times with six deaths soon after the operation. One of his patients survived the operation four years and nine months. He also stated, in some clinical remarks, that the late Professor Schuh had had one case of four years, and another of seven years, the former being still alive, and in excellent health. In a remarkable case in which four inches of the rectum, along with the prostate gland and a portion of the neck of the bladder, were removed by Professor Nussbaum, of Munich, life was prolonged three years. In four additional instances, the patients lived in ease and comfort many months, and even several years, before relapse took place. One of the most successful operations in this country is that recorded by the late Professor March, of Albany, of a woman, twenty-six years of age, in which the disease, situated about an inch and a half above the verge of the anus, involved the entire circumference of the bowel, it being particularly prominent in front in the direction of the vagina. The entire mass was removed with the bistoury and scissors, the edges of the wound being tacked together with six interrupted sutures immediately within the sphincter muscle. Rapid recovery ensued, and, when last heard from, six months after the operation, the case was doing well.

The patient, in this operation, is placed upon his back as in lithotomy, when a catheter is inserted into the bladder, and an incision made in the direction of the coccyx. The diseased structures are then dissected from the surrounding parts with the bistoury and curved scissors, after which the edges of the wound in the bowel and skin are tacked together in the usual manner. Care is taken not to injure the bladder, urethra, or vagina. The operation is nearly always very bloody, especially if the vessels are not secured as fast as they are divided. The after-treatment is conducted upon general principles.

As a temporary expedient, designed to prolong existence, the rectum may occasionally be slightly notched at the contracted part, a tent being left in the bottom of the fissure to insure patency. Or, what is preferable, and less likely to cause serious hemorrhage, the stricture is broken down with the finger, or a stout bougie, well oiled and forcibly inserted. The relief which follows this operation is very great, and often lasts for months, the patient experiencing little, if any, difficulty in voiding his feces. I have performed the operation with the finger repeatedly, and always with happy results. I heard of a case, not long ago, in which a bougie was forced through the strictured part into the pelvic cavity. It is needless to add that the patient died of peritonitis. When the disease involves the anus, any nodules at its verge or within its orifice that may be a source of obstruction, pain, or annoyance should be snipped off with the scissors, or destroyed with the actual cautery.

NEURALGIA OF THE ANUS AND RECTUM.

Neuralgia of the anus and rectum is most common in persons of a nervous, irritable temperament, from the age of twenty-five to fifty; it usually coexists, or alternates, with attacks of a similar kind in other parts of the body, particularly the face, stomach, testicle, mamma, and bladder. It is characterized by paroxysms

of pain, which is generally described as of a tearing, burning, or lancinating nature, situated at the extremity of the lower bowel, from which it is apt to extend to the sacrum, loins, pubes, and genito-urinary organs. Defecation is exquisitely painful, and the urine is discharged in jets or drops, attended with a scalding sensation. The attacks commonly subside in from five to ten hours, to recur with tolerable regularity about the same period the next day, although sometimes not until the second or third. During the intermissions, the patient is, in great degree, free from pain, and passes his feces and urine without difficulty. The affection often continues for years, and the paroxysms are then apt to be more frequent and irregular, recurring, perhaps, every few hours.

The causes of neuralgia are various. It often arises from disease of the ano-rectal region, or from the pressure exerted upon the lower bowel by an enlarged prostate or a retroverted womb. In hemorrhoids, strictures, fissure, and other maladies, the pain frequently derives its chief severity from its neuralgic character. Sometimes the disease is of a miasmatic origin, especially in persons living in malarious regions, infested with intermittent fever. When this is the case, it generally recurs in regular paroxysms, once every twenty-four hours or every third day. Again, cases occur in which it appears to be owing simply to derangement of the digestive apparatus, as dyspepsia, constipation, worms, or disordered biliary secretion. Neuralgia of the anus and rectum frequently alternates with neuralgia of other parts. I have seen quite a number of cases in which it was thus associated with neuralgia of the chest, face, and testes. In the female, the malady is sometimes connected with dysmenorrhœa. The most atrocious attacks that I have ever witnessed were caused by the impaction in the rectum of indurated fecal matter.

As this disease never proves fatal, it is impossible to affirm what its real pathology is. In our examinations of such cases, we occasionally detect, a short distance above the anus, or even within the anus itself, a small spot, so exquisitely sensitive as to cause the most excruciating suffering, and this, perhaps, even when there is no inflammatory redness, ulceration, or appreciable disease whatever.

Neuralgia of the rectum must be treated according to the nature of its exciting cause, which should, therefore, always, if possible, be sought out, and removed. Thus, if there be hemorrhoids, stricture, or ulceration, no decided impression can be made upon the case until these affections are disposed of. As there is almost always manifest derangement of the digestive organs, either as a cause or an effect of the malady, a mild, but systematic, course of purgation, constitutes, generally, a primary object in the treatment. On no account should the rectum be allowed to become distended with fecal matter, as this may, of itself, be sufficient to bring on and keep up neuralgia of this tube in its most violent forms. After due attention has been bestowed upon the secretions of the stomach, liver, and bowels, the most appropriate remedies will be quinine, iron, arsenic, and strychnia, in quantities suited to the age, habits, and temperament of the individual. When the paroxysms observe a regular periodicity, the quinine should be given in large doses, as ten grains, combined with one-third of a grain of morphia, every six, eight, or twelve hours, until the disease is broken up. During the attacks, anodyne enemata, suppositories, and fomentations will be beneficial. Despite, however, all these and other means, the malady often continues, with more or less mitigation, for years, baffling the skill of the practitioner, and compelling the patient to eke out a miserable existence.

SPASM OF THE SPHINCTER MUSCLES OF THE ANUS.

This complaint, which is by no means uncommon, is liable to occur at all periods of life, under the influences of various causes, of which the most frequent are, fissure and fistule of the anus, inflammation of the mucous membrane, hemorrhoids, various kinds of morbid growths, as polyps and carcinoma, and the presence of ascarides and foreign bodies. In many cases it is directly traceable to disease of the neighboring organs, as stricture of the urethra, irritation of the bladder, and inflammation, ulceration, or prolapse of the uterus. Simple disorder of the digestive apparatus is sufficient to occasion it, and the agency exerted in producing it by neuralgia, diarrhœa, and dysentery, is familiar to every practitioner.

The disease, which may be temporary or permanent, presents itself in various degrees, from the slightest suffering to the most frightful torture. I have repeatedly met with instances in which it had persisted, with occasional intermissions, for

can easily be felt at each side of the anus, both through the skin and mucous membrane, as firm, rigid cords, with, perhaps, here and there, a phlebolite. Not unfrequently, indeed, they may readily be distinguished by their bluish appearance alone. When it is remembered that these vessels are destitute of valves, and that they are constantly subjected to motion and pressure, it is not surprising that they should become diseased, and ultimately varicose.

Varicose enlargement of the hemorrhoidal veins should not be confounded with hemorrhoidal tumors, which it so often accompanies, as it is very different from that affection. It is characterized by a sensation of weight and fullness in the ano-pelvic region, by vague, uneasy feelings in the perineum, sacrum, and loins, and by smarting, burning, or stinging pains during defecation, and for a short time after. On inserting the forefinger into the bowel, and applying the thumb to the surface of the anus, the affected vessels may easily be felt like so many separate cords, or like scattered earth worms. The general health is not necessarily impaired, although it is often deranged, more frequently, perhaps, as a cause than as an effect of the complaint.

Few surgeons, I imagine, would be found bold enough to attempt the obliteration of these vessels with the ligature, and yet such an operation might not, perhaps, involve any greater risk than the tying of a number of large hemorrhoidal tumors. When the disease is a source of constant suffering, linear eschars might be made over a few of the largest veins by means of the Vienna paste, a procedure which may be regarded as perfectly safe, judging from the experience we have of this treatment in varicose enlargement of the veins of the leg. Much may be done in such a case, in the way of palliation, by attention to the bowels and diet, by an avoidance of the exciting causes of the disease, by cold enemata, and by frequent ablutions with soap and water.

ANAL TUMORS.

Pendulous tumors, frequently the result of external hemorrhoids, form around the anus, just at its verge, or at the junction of the mucous and cutaneous surfaces. They are generally soft, irregularly globular, or pear-like in shape, smooth, or rough, and of a solid, fibroid structure. Occasionally, however, they are composed of a spongy, erectile substance, not unlike that of the cavernous body of the penis, and, therefore, liable to bleed after excision. I believe that this form of tumor is more common than is usually supposed, inasmuch as a number of well-marked examples of it have fallen under my observation. Its vessels are apparently merely prolongations of the smaller hemorrhoidal veins, in a state of dilatation and varicosity, and closely invested by rather dense cellular substance. In size, such an excrescence may equal the end of the little finger; its color usually resembles that of the skin, or the mucocutaneous tissues, to which it is attached; it is sometimes solitary, but more frequently multiple. When these growths are very numerous, they may form a complete chaplet around the anus, causing much trouble in walking and defecation. Venereal warts and tubercles also occur in this situation, both in children and in adults, the former as an effect of local, the latter of constitutional, contamination. Finally, an instance of the true sebaceous tumor is occasionally seen here. It is easily recognized by its indolent character, doughy consistence, and pale color.

If troublesome, these circumanal growths may be removed with the knife, or snipped off with the scissors. The erectile tumor should, however, always be tied, on account of its liability to hemorrhage; or, if excision has been practised, and bleeding ensue, ligation must follow the knife, the edges of the wound being raised with the tenaculum, and firmly tied. In a case of this kind, in a patient of Dr. O'Reilly, I was finally compelled, after unavailing efforts with other means, to adopt this measure, using both the twisted and the interrupted suture, profuse bleeding having come on within an hour after I had cut off five or six of these excrescences. Venereal warts may be excised, or destroyed with chromic acid, dry lint being interposed in the intervals of the application. Syphilitic tubercles require the ordinary topical and constitutional treatment. Sebaceous tumors are extirpated.

The duration of the pruritus is extremely variable, lasting sometimes only a few days or weeks; at other times as many months. Once fairly rooted, it may persist, despite our remedies, for an indefinite period. In one case I knew it to continue, with an occasional intermission, for sixteen years, and in another for upwards of twenty, before it finally disappeared. It is commonly worse in cold than in warm weather, and at night than in the day. At night, indeed, it is often so severe as to prevent sleep for hours together, or, if the patient is so fortunate as to sink off into a doze, he soon wakes himself up by scratching and rubbing the part. Sometimes the disease unexpectedly disappears, the person imagining himself well, when, all of a sudden, either without any obvious cause, or from the slightest irregularity of diet, fatigue, loss of rest, or exposure to heat, it returns with all its former severity.

The cause of pruritus is often difficult of detection. The complaint is unquestionably, in many cases, associated with disorder of the anus or ano-rectal region, as hemorrhoids, stricture, sacciform disease, and the presence of ascarides; but whether it is produced by it has not been determined. We certainly every day see cases of these affections without the occurrence of pruritus. In most of the instances of the latter complaint that have come under my observation I have been disposed to ascribe its origin to some derangement of the digestive apparatus, as dyspepsia and constipation, attended with an irritable state of the constitution, and to regard it as a kind of safety-valve, designed to protect other and more important parts from disease.

In the treatment of this affection, a primary object should be to inquire into the condition of the anus and digestive organs, with a view to the rectification of any disorder that may be supposed to be capable of exerting an influence in producing and perpetuating it. If the general health is impaired, no improvement will be likely to take place in the local disease until this has been restored. In some cases tonics, as iron and quinine, may be demanded, while in others directly opposite measures may be indicated, depending upon the state of the system. In almost every instance a regular systematic course of purgatives, consisting of blue mass or the compound calomel pill, along with iodide of potassium, or, in plethoric subjects, antimonial and saline preparations, in small doses, will be serviceable. In anemic subjects, tincture of chloride of iron, in union with Fowler's solution of arsenic and a minute quantity of bichloride of mercury, is usually highly beneficial. The diet must be bland and unirritant. The most useful topical remedies are the yellow wash, solutions of acetate of lead and laudanum, lotions of permanganate of potassa, and various kinds of ointments, as the zinc, tar, and citrine, the latter greatly diluted. Cold ablutions with castile soap afford marked relief, and are indispensable to the patient's comfort. In obstinate cases, resisting the ordinary remedies, slight pyalism, maintained for several weeks, should be tried.

TRICHIASIS OF THE ANUS.

This affection, which has its analogy in trichiasis of the eye, has not, so far as I know, been before described. As the name implies, it essentially consists in an inversion of the hairs which naturally grow around the verge of the anus, and which, when the inversion is habitual or considerable, often cause a great deal of itching and irritation, either with or without discharge of mucous and other fluids. One of the best examples of this affection that I have ever seen occurred in a middle-aged gentleman on whom I operated many years ago for fissure of the anus. The ulcer was very deep seated, and it was, therefore, necessary to divide the sphincter muscles to their full extent. The wound was long in healing, owing, partly, to his dilapidated health, and partly to the inversion of the hairs around the anus, which had to be repeatedly clipped to prevent irritation.

Some persons seem to be naturally predisposed to this affection, owing to the irregular growth of the hairs around the anus. The trouble will be likely to be much increased when the hairs are unusually numerous, long, and stiff. The true nature of the case can only be determined by careful inspection. The only thing to be done is to trim the offending hairs occasionally with the scissors; but on no account should they be shaved off, as this would be certain eventually to aggravate the complaint by rendering the new growth more stiff and irregular.

When the hair around the anus is very abundant, it may entangle the secretions

The only remedy is removal by ligature or torsion. If the tumor is small, and situated just above the verge of the anus, it may be seized with a pair of long, slender forceps, and twisted upon its axis until it drops off, the procedure being conducted in the same manner as in the removal of a nasal polyp; but, under opposite circumstances, or when the growth is very vascular, the safer plan is to tie it, and let it slough off. Finally, when this is impracticable on account of the great height of the tumor, it may readily be destroyed by crushing or strangulation by means of the *écraseur*. The objection to excision is its liability to hemorrhage, which is sometimes so great as to endanger life, and which it might be difficult to arrest, especially when the tumor is seated at a considerable distance from the anus.

PAPILLARY TUMORS.

This is a form of soft tumor of the mucous membrane of the rectum, similar to what is met with in the vesical trigone, and attended with the same local symptoms as polypoid growths, from which, however, it may readily be distinguished by its physical and microscopical appearances. Originally described by Rokitansky under the name of villous cancer, although it is not, as he supposes, of a malignant nature, the growth is occasionally observed in children, but is most common in elderly subjects, in whom it may exceed the volume of a hen's egg. It consists mainly of elongated villi, reposing upon a broad body, covered by one or more layers of cylindrical epithelium, and extremely vascular, the veins being much enlarged and varicose. Such a growth causes a most distressing sense of fullness in the bowel, as if it were obstructed by a foreign body; and is liable to copious hemorrhage, which sometimes seriously undermines the vital powers. The proper remedy is extirpation, or strangulation with a double ligature.

STRICTURE OF THE RECTUM AND ANUS.

It is difficult to believe that simple stricture of the rectum, such as is so often witnessed in the urethra and other mucous canals, is as common as is generally supposed. My conviction is that it is one of those affections which are much more frequently described than observed. I have certainly very rarely met with it, nearly all the cases of stricture of the lower bowel that have come under my notice having been of a carcinomatous nature.

The most common seat of the disease is from two and a half to three and a half inches above the verge of the anus, or easily within reach of the index-finger. Affecting

Fig. 477.



Stricture of the Rectum.

generally only a portion of the tube, it sometimes reaches around its entire circumference, as in fig. 477, its vertical extent being seldom less than twelve, fifteen, or eighteen lines. The degree of its encroachment upon the caliber of the gut varies from the slightest diminution to almost complete obliteration, the orifice of the stricture being sometimes scarcely large enough to admit of the passage of a goose-quill. The immediate cause of the disease is an effusion of plastic matter into the submucous cellular tissue, the other tunics retaining their integrity, or, at all events, experiencing only a slight change of consistence. This substance soon becomes organized, and gradually assumes a dense, fibrous character, creaking under the knife, and exhibiting a grayish or bluish-white appearance. The tendency of the disease is to extend inwards towards the caliber of the tube, so as to encroach upon the mucous membrane, which, although it may long retain its integrity,

finally yields to the morbid action, becoming adherent to the subjacent parts, and at length ulcerated at different points. The period at which this occurs varies from several months to as many years.

It is not always, or perhaps even generally, possible to trace this disease to any particular cause. In the very few cases that have fallen under my observation, no clue whatever could be obtained as to its origin. It is not unlikely that it may be

posed of a fold of mucous membrane, of a circular shape, and is always easily detected with the probe or finger. During the cries of the child, and especially during straining, in attempts at defecation, it is sometimes forced down almost within reach of the eye, forming a dusky, fluctuating protrusion. In the second variety of occlusion, of which fig. 478, from Ashton, affords a graphic illustration, the obstruction is caused by fibrous matter, which often extends to the height of an inch, and even an inch and a half, constituting thus a most formidable barrier. Finally, the rectum is sometimes entirely absent, the intestinal tube terminating in a cul-de-sac, or opening, as previously stated, at some unnatural point. However this may be, the pelvis is generally abnormally small, and there is no trace whatever of an anus. In rare cases, the absent canal is represented by a fibro-ligamentous cord, attached to the colon, and descending along the sacrum towards the neck of the bladder, where it is lost in the cellular substance.

The most simple form of occlusion of the rectum admits of relief by a very easy procedure, consisting in a crucial division of the septum, with or without removal of the angles of the wound, and the occasional introduction of the mother's finger, which is, in all such cases, the best bougie. In the other variety, a severe operation is required, and that, too, in many cases, without any certainty of ultimate success. The child being held upon the lap of an assistant, the breech is exposed as in lithotomy, and an incision made through the posterior part of the raphé of the perineum, the knife being carried up in the direction of the curve of the sacrum to the distance, if necessary, of two or three inches, the left index-finger serving as a guide to the instrument. The operation is done slowly and cautiously, care being taken to avoid the bladder and urethra in front, the great pelvic vessels at the sides, and the sacrum posteriorly, lest, as it respects the latter, the knife pass behind the tube of which it is in search. Patency and dilatation are promoted by tents and bougies, cautiously used for a long time afterwards, and aided, if requisite, by an occasional touch of the bistoury, to counteract the tendency to closure, which is always great in such cases.

An operation similar to the one just described may be performed when the rectum is absent, although with hardly any possibility of a successful issue; for, even supposing that the canal could be reached, the child would be likely to perish from peritoneal inflammation, induced either by the incision of the intestine, or by the extravasation of fecal matter. Still, it is justifiable, because there is no other chance of relief, except by the establishment of an artificial anus in the lumbar region; a procedure not only fraught with danger, but, in all respects, so undesirable as hardly to be thought of by any right thinking surgeon, for life, in such a condition, would certainly not be worth having.

The rectum, instead of terminating at the anus, occasionally opens by a narrow canal into the *urinary* passages, generally at the posterior part of the urethra, or at the bas-fond of the bladder, a short distance below the insertion of the ureter; the former mode of communication being the more frequent. The malformation is almost peculiar to males, and generally proves fatal within a few days after birth, on account of the small size of the recto-vesical outlet not allowing of a sufficiently free discharge of fecal matter. To this rule, however, occasionally an exception occurs. Thus, in a case which I attended with Dr. Kempf, and in which I made a very deep incision without reaching the bowel, the child survived six weeks, passing daily a little fecal matter by the urethra. An uncle of the child had lived in a similar condition for upwards of thirty years. Such a vice of formation is generally beyond the surgeon's skill; still, when the danger is imminent, an attempt should be made to reach the bowel by cutting along the sacrum, a staff being inserted, if possible, into the recto-vesical orifice as a guide to the instrument.

When the rectum terminates in the *vagina*, the opening is usually situated low down, and is a good deal larger than when the bowel communicates with the urinary passages, although seldom equal to nature's wants. On this account, and also for the purpose of freeing the vagina, an attempt should be made to establish an opening at the usual site of the anus. The operation is very simple, the knife being carried from before backwards, in the direction of the raphé of the perineum. The skin and mucous membrane may afterwards be tacked together, and reclosure prevented by the finger and bougie. The fissure in the vagina may be obliterated, at a subsequent period, by several points of suture.

The syphilitic form of stricture of the rectum, or of the rectum and anus, must be treated with astringent and anodyne enemas, dilatation with the bougie, and cautious incisions. The general health is amended by tonics, a generous diet, and nutritious drinks. Mercury and iodide of potassium are of no avail.

CARCINOMA OF THE ANUS AND RECTUM.

Carcinoma of the anus and rectum may exist as a primary disease, or as a propagation from the adjacent parts, as the uterus and vagina, or the pelvic lymphatic glands. The most common form in which it appears is epithelioma, occurring either as an infiltration in the connecting cellular substance, or as a tumor of variable size and shape, and of the consistence which ordinarily appertains to canceroid disease in other situations. Of scirrhus, encephaloid, and colloid of the ano-rectal region very little is known, as they have been noticed only in a few instances. The same remark is strictly applicable to melanosis, of which I have myself witnessed only one example. The patient, a man fifty-eight years old, labored under the same disease in nearly all the principal organs of the body, and died, after an illness of upwards of twelve months, in a state of the utmost emaciation. His principal symptoms, as it respected the anus and bowel, were, frequent discharges of muco-purulent matter, often streaked with blood, diarrhoea, griping, tenesmus, flatulence, and, at length, total loss of power in the sphincter muscles. Several black tumors, hard, irregular in shape, and about the size of small grapes, existed at the verge of the anus; and the finger, carried into the rectum, readily came in contact with a hard cancerous mass, which, on dissection, was found to consist of a mixture of scirrhus and melanosis. The prostate gland was somewhat enlarged, and the bladder had evinced great impatience of its contents during the last five or six months.

Epithelioma of the ano-rectal region is most common in elderly subjects, but I have repeatedly observed it in young adults, and a case has been reported of ulcerated carcinoma of the rectum in a child twelve years of age. One of the very worst examples of carcinoma of the anus, as it respected the rapidity and extent of the malady, that I have ever witnessed, occurred in a man scarcely twenty-two years old. When I first saw him the disease had already attained an extraordinary development, and was attended with great contraction of the anus. My opinion is that epithelioma in both these localities is much more common in young persons than is generally supposed. It is not known what influence, if any, sex exerts upon the production of primary carcinoma here; the prevalent belief is that it is most frequent in the female, but this is opposed to my experience, which has supplied me with a much larger number of cases in the male. Secondary carcinoma, on the contrary, is most common in women, owing to their great liability to carcinoma of the uterus, and the remarkable facility with which the malady, when it occurs here, extends to the vagina, anus, and rectum.

The ordinary site of the disease is at a height of two and a half to three inches from the verge of the anus, or at a point that is generally readily accessible by the finger. Examples, however, occur where it is located further up, or lower down. In the latter case, the malady sometimes coexists with epithelioma of the anus. The most common form in which the heterologous matter exhibits itself in the rectum is the tuberoid, the nodules varying in size from a pea up to that of a pullet's egg, and in consistence from hard cheese to that of fibro-cartilage, their color being usually florid, grayish, or light drab. When the deposit is large, it may involve the whole circumference of the cylinder. It is generally supposed that the posterior portion of the tube is more prone to suffer than the anterior or lateral, but this is very questionable. When the morbid substance occurs as an infiltration in the wall of the rectum, it always exists more conspicuously in the submucous cellular tissue, which has a dense, gristly appearance, intersected by bluish bands, which give the parts an alveolar structure, similar to that of carcinoma of the stomach and œsophagus. When the disease is situated at the anus, it always observes the tuberiform character, and is generally attended with extraordinary hardness. In whatever form it occurs, or whichever of these parts it affects, it is sure, in time, to encroach very seriously upon the caliber of the tube, and finally even to lead to such a degree of occlusion as to prevent effectually the discharge of fecal matter. I have seen numerous cases where the opening was hardly large enough to admit the point of the little finger. The tube above the seat of the obstruction may retain its

natural size, or be somewhat dilated. The period which elapses from the first appearance of the disease to its ultimate termination varies, on an average, from one to two years. As a general rule, epithelioma of the rectum will be found to destroy life sooner, by several months, than epithelioma of the anus.

The *symptoms* of carcinoma of the ano-rectal region are, at first, often obscure, being such, mainly, as attend some of the other affections already described. As the disease, however, progresses it acts not only obstructingly, but gives rise to sharp, lancinating pains, extending into the thighs, nates, perineum, and sacrum, and accompanied with a sense of weight and pressure low down in the pelvis. Defecation is gradually impeded; the patient is obliged to strain a great deal at stool, the calls to which are often unnaturally frequent; and the feces are passed in a flattened, ribbon-like form, instead of being cylindrical, as in the natural state. Very often the only substance evacuated is a thick, glairy mucus, perhaps streaked with blood, or blood and pus, which are liable to be poured out in large quantity, and to escape almost incessantly, thus compelling the sufferer to wear a cloth to keep himself clean and comfortable. The bladder is usually rendered irritable, even at an early period, especially when the disease is located at the anterior wall of the rectum, or the fore-part of the anus; the bowels are habitually distended with feces and gas; the general health gradually fails; the emaciation steadily progresses; and the countenance assumes the peculiar sallow aspect so characteristic of the carcinomatous cachexia.

When the disease, whether seated in the anus or rectum, is fully established, the patient finds it extremely difficult, if not impossible, to sit upright upon his chair. In general, he is obliged to support himself upon one of his nates, or alternately upon the one and the other. In a case which I recently saw along with Professor Pancoast, the patient, a lady, forty-three years of age, affected with epithelioma of the rectum of about sixteen months' standing, was nearly constantly compelled, in order to make herself comfortable, to sit with her head bent forwards over her knees. At night she found great relief by lying with her hands spread out under the buttocks.

The *diagnosis* is generally sufficiently simple, especially after the disease has made some progress. The peculiar character of the pain, the indurated condition of the parts, the gradual contraction of the caliber of the tube, the obstruction to defecation, the abundant mucous or muco-puriform secretion, and its involuntary escape at the anus, the constant distention of the bowels, the flattened character of the feces, and the difficulty of introducing fluids or solids into the rectum, or through the anus, together with the progressive emaciation and failure of the general health, are always unmistakable evidences of the nature of the malady. In carcinoma, the rectum never descends as it does in prolapse and in hemorrhoids; no openings exist around the anus, as in fistule, or, at any rate, very seldom; and there is not that severe spasmodic pain during defecation and for some time after that attends fissure of the anus. Besides, in all these affections, which are more liable to simulate carcinoma than any others, a digital examination may usually be made with comparative ease, on account of the more yielding nature of the parts. Polypoid growths, enlargement of the prostate gland, a retroverted uterus, and the presence of a pessary, are always easily detected by the finger.

Care should be taken not to mistake an enlargement of the lymphatic glands of the pelvis for this affection. These glands are liable, from various causes, as simple ulceration of the anus and rectum, and disease of the bladder, vagina, and uterus, to increase in bulk, so that they may readily be felt as hard, nodular masses through the bowel, and might thus lead to the idea of the existence of epithelioma.

The *treatment* must be conducted upon the same general principles as in carcinoma in other situations. Palliation being all that is to be hoped for in any case, the measures must be chiefly of a soothing and detergent character, consisting of enemata of tepid water, or of tepid water and olive oil, to insure cleanliness and patency of the lower bowel, of frequent ablutions when the disease is external, or when there is much discharge, and of anodyne suppositories, or opiate injections to allay pain and spasm. Fœtor is best relieved with weak lotions and enemata of permanganate of potassa. When there is much heat in the parts, attended with a sense of weight, leeches and the warm water-dressing, simple or medicated, will prove beneficial. The bowels are evacuated in the recumbent position; all sexual excitement is avoided; and the general health is carefully watched and superintended, the food being non-stimulant, concentrated, and nutritious. In the latter stages,

tonics and alcoholic drinks will be necessary, with the internal use of morphia, soda, and carminatives, to calm and soothe the stomach and bowels.

The employment of the bougie in the treatment of carcinomatous affections of the anus and rectum is of doubtful utility, if not decidedly prejudicial. During their earlier stages, and especially in cases attended with inordinate coarctation, while ulceration is not yet impending, the cautious passage of such an instrument, every third or fourth day, may be productive of some benefit in widening the tube, and thus facilitating the evacuation of its contents; but beyond this no advantage is to be anticipated, while its more frequent use could hardly fail to be a source of irritation and mischief. A gum-elastic bougie, well oiled, and retained for five or ten minutes within the constricted part, would be the most eligible instrument.

Excision is not only a dangerous procedure, but seldom affords more than temporary relief from pain and fecal obstruction. When the anus is involved, the operation must, of course, include the sphincter muscles, thereby depriving the patient of the power of controlling his passages, and the same result will be sure to follow, sooner or later, excision of a portion of the rectum, to say nothing, in the latter case, of the immediate risk to life from hemorrhage, peritonitis, and phlebitis.

Professor Billroth, of Vienna, in 1868 informed me that he had excised the anus and lower portion of the rectum upwards of a dozen times with six deaths soon after the operation. One of his patients survived the operation four years and nine months. He also stated, in some clinical remarks, that the late Professor Schuh had had one case of four years, and another of seven years, the former being still alive, and in excellent health. In a remarkable case in which four inches of the rectum, along with the prostate gland and a portion of the neck of the bladder, were removed by Professor Nussbaum, of Munich, life was prolonged three years. In four additional instances, the patients lived in ease and comfort many months, and even several years, before relapse took place. One of the most successful operations in this country is that recorded by the late Professor March, of Albany, of a woman, twenty-six years of age, in which the disease, situated about an inch and a half above the verge of the anus, involved the entire circumference of the bowel, it being particularly prominent in front in the direction of the vagina. The entire mass was removed with the bistoury and scissors, the edges of the wound being tacked together with six interrupted sutures immediately within the sphincter muscle. Rapid recovery ensued, and, when last heard from, six months after the operation, the case was doing well.

The patient, in this operation, is placed upon his back as in lithotomy, when a catheter is inserted into the bladder, and an incision made in the direction of the coccyx. The diseased structures are then dissected from the surrounding parts with the bistoury and curved scissors, after which the edges of the wound in the bowel and skin are tacked together in the usual manner. Care is taken not to injure the bladder, urethra, or vagina. The operation is nearly always very bloody, especially if the vessels are not secured as fast as they are divided. The after-treatment is conducted upon general principles.

As a temporary expedient, designed to prolong existence, the rectum may occasionally be slightly notched at the contracted part, a tent being left in the bottom of the fissure to insure patency. Or, what is preferable, and less likely to cause serious hemorrhage, the stricture is broken down with the finger, or a stout bougie, well oiled and forcibly inserted. The relief which follows this operation is very great, and often lasts for months, the patient experiencing little, if any, difficulty in voiding his feces. I have performed the operation with the finger repeatedly, and always with happy results. I heard of a case, not long ago, in which a bougie was forced through the strictured part into the pelvic cavity. It is needless to add that the patient died of peritonitis. When the disease involves the anus, any nodules at its verge or within its orifice that may be a source of obstruction, pain, or annoyance should be snipped off with the scissors, or destroyed with the actual cautery.

NEURALGIA OF THE ANUS AND RECTUM.

Neuralgia of the anus and rectum is most common in persons of a nervous, irritable temperament, from the age of twenty-five to fifty; it usually coexists, or alternates, with attacks of a similar kind in other parts of the body, particularly the face, stomach, testicle, mamma, and bladder. It is characterized by paroxysms

of pain, which is generally described as of a tearing, burning, or lancinating nature, situated at the extremity of the lower bowel, from which it is apt to extend to the sacrum, loins, pubes, and genito-urinary organs. Defecation is exquisitely painful, and the urine is discharged in jets or drops, attended with a scalding sensation. The attacks commonly subside in from five to ten hours, to recur with tolerable regularity about the same period the next day, although sometimes not until the second or third. During the intermissions, the patient is, in great degree, free from pain, and passes his feces and urine without difficulty. The affection often continues for years, and the paroxysms are then apt to be more frequent and irregular, recurring, perhaps, every few hours.

The causes of neuralgia are various. It often arises from disease of the ano-rectal region, or from the pressure exerted upon the lower bowel by an enlarged prostate or a retroverted womb. In hemorrhoids, strictures, fissure, and other maladies, the pain frequently derives its chief severity from its neuralgic character. Sometimes the disease is of a miasmatic origin, especially in persons living in malarious regions, infested with intermittent fever. When this is the case, it generally recurs in regular paroxysms, once every twenty-four hours or every third day. Again, cases occur in which it appears to be owing simply to derangement of the digestive apparatus, as dyspepsia, constipation, worms, or disordered biliary secretion. Neuralgia of the anus and rectum frequently alternates with neuralgia of other parts. I have seen quite a number of cases in which it was thus associated with neuralgia of the chest, face, and testes. In the female, the malady is sometimes connected with dysmenorrhœa. The most atrocious attacks that I have ever witnessed were caused by the impaction in the rectum of indurated fecal matter.

As this disease never proves fatal, it is impossible to affirm what its real pathology is. In our examinations of such cases, we occasionally detect, a short distance above the anus, or even within the anus itself, a small spot, so exquisitely sensitive as to cause the most excruciating suffering, and this, perhaps, even when there is no inflammatory redness, ulceration, or appreciable disease whatever.

Neuralgia of the rectum must be treated according to the nature of its exciting cause, which should, therefore, always, if possible, be sought out, and removed. Thus, if there be hemorrhoids, stricture, or ulceration, no decided impression can be made upon the case until these affections are disposed of. As there is almost always manifest derangement of the digestive organs, either as a cause or an effect of the malady, a mild, but systematic, course of purgation, constitutes, generally, a primary object in the treatment. On no account should the rectum be allowed to become distended with fecal matter, as this may, of itself, be sufficient to bring on and keep up neuralgia of this tube in its most violent forms. After due attention has been bestowed upon the secretions of the stomach, liver, and bowels, the most appropriate remedies will be quinine, iron, arsenic, and strychnia, in quantities suited to the age, habits, and temperament of the individual. When the paroxysms observe a regular periodicity, the quinine should be given in large doses, as ten grains, combined with one-third of a grain of morphia, every six, eight, or twelve hours, until the disease is broken up. During the attacks, anodyne enemas, suppositories, and fomentations will be beneficial. Despite, however, all these and other means, the malady often continues, with more or less mitigation, for years, baffling the skill of the practitioner, and compelling the patient to eke out a miserable existence.

SPASM OF THE SPHINCTER MUSCLES OF THE ANUS.

This complaint, which is by no means uncommon, is liable to occur at all periods of life, under the influences of various causes, of which the most frequent are, fissure and fistule of the anus, inflammation of the mucous membrane, hemorrhoids, various kinds of morbid growths, as polyps and carcinoma, and the presence of ascarides and foreign bodies. In many cases it is directly traceable to disease of the neighboring organs, as stricture of the urethra, irritation of the bladder, and inflammation, ulceration, or prolapse of the uterus. Simple disorder of the digestive apparatus is sufficient to occasion it, and the agency exerted in producing it by neuralgia, diarrhœa, and dysentery, is familiar to every practitioner.

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The disease, which may be temporary or permanent, presents itself in various degrees, from the slightest suffering to the most frightful torture. I have repeatedly met with instances in which it had persisted, with occasional intermissions, for

years, rendering life literally miserable. My experience is that females are more liable to it than males; but this may have been a mere coincidence, depending upon a peculiar run of cases.

The most prominent symptoms are, difficulty in defecation, an almost constant sense of uneasiness in the region of the anus and rectum, and more or less straining and bearing down at the water-closet. The feces, if hard, are usually voided in narrow cylinders, often streaked with blood, and the pain occasioned by their passage frequently continues for hours afterwards. The general health at length gives way; flatulence and indigestion supervene, the bowels are habitually constipated, the countenance assumes a peculiar sallow appearance, and the temper becomes peevish and fretful. If an attempt be made to insert the finger or speculum into the anus, great resistance will be experienced, the parts feeling like a firm, rigid ring; and the effort will be sure to create almost insupportable pain and distress. The diagnosis may usually be easily determined by a careful examination of the parts. Fissure of the anus, neuralgia, hemorrhoids, stricture, and carcinoma are the affections with which the disease is most liable to be confounded.

To lay down a definite plan of treatment for a malady which may have its origin in so great a diversity of causes is obviously an impossibility. The first thing to be done is, of course, to ascertain the nature of the exciting cause; for upon the knowledge thus obtained must essentially depend the success of our therapeutic and operative measures. The general health must be amended, the secretions corrected, tumors removed, and ulcers cauterized or divided. The milder forms of the disease will often recover under the use of chalybeate tonics, gentle laxatives, exercise in the open air, a properly regulated diet, and belladonna ointment. When the disease is obstinate, and unconnected with any obvious structural disorder of the anus or rectum, a radical cure may commonly be promptly effected by the forcible extension of the sphincter muscles with the thumbs and fingers, as in the treatment of fissure of the anus, suggested by Recamier. This plan has answered admirably in my hands in a number of instances. When it fails, the only resource is the subcutaneous division of the sphincter muscles with a delicate tenotome. In transient cases, dependent upon dysenteric irritation, immediate relief generally follows forcible stretching of the sphincter muscles.

PRURITUS OF THE ANUS AND NATES.

The skin at and immediately around the anus is liable to pruritus, a peculiar form of itching, frequently as obstinate as it is annoying. The affection is most common in middle-aged and elderly subjects, particularly such as are of a weakly constitution, or inclined to dyspepsia and irregularity of the bowels. I have, however, repeatedly witnessed it in persons apparently in the most perfect health. Occasionally it occurs during pregnancy, coming on soon after conception, and going off gradually after delivery. Women who have recently ceased to menstruate are also liable to it. Persons of a light, delicate skin, florid complexion, and red hair, are particularly prone to the complaint; but, from what I have seen of it, I am inclined to believe that no physical organization, temperament, or occupation is entirely exempt from it.

The disease consists essentially in an eczematous condition of the skin, which is covered with exceedingly minute vesicles, scarcely as large as the smallest pin-head, and occupied by a thin, watery fluid. When these vesicles break, they leave little sores, discharging an irritating sanies, which, as it dries, sometimes forms little incrustations upon the surface. Instead of vesicles, small cracks or chaps occasionally appear upon the skin around the anus, similar to those so often met with on the lips and nose. The affected surface is generally very limited, perhaps not exceeding in size a quarter of a dollar. From the constant rubbing to which it is subjected, it is liable, in time, to become indurated, stiff, thickened, and furrowed; from the same cause, or even from the mere friction of the buttocks in locomotion, it is apt to become inflamed and painful, producing difficulty in walking, riding, and even in sitting. I have known the pain thus occasioned to extend down along the corresponding limb as far nearly as the heel. In bad cases, the disease may spread over a considerable surface, and even attack the buttock, perineum, scrotum, and thigh. More remote parts, too, may suffer, as the face, neck, nose, and eyelids.

The duration of the pruritus is extremely variable, lasting sometimes only a few days or weeks; at other times as many months. Once fairly rooted, it may persist, despite our remedies, for an indefinite period. In one case I knew it to continue, with an occasional intermission, for sixteen years, and in another for upwards of twenty, before it finally disappeared. It is commonly worse in cold than in warm weather, and at night than in the day. At night, indeed, it is often so severe as to prevent sleep for hours together, or, if the patient is so fortunate as to sink off into a doze, he soon wakes himself up by scratching and rubbing the part. Sometimes the disease unexpectedly disappears, the person imagining himself well, when, all of a sudden, either without any obvious cause, or from the slightest irregularity of diet, fatigue, loss of rest, or exposure to heat, it returns with all its former severity.

The cause of pruritus is often difficult of detection. The complaint is unquestionably, in many cases, associated with disorder of the anus or ano-rectal region, as hemorrhoids, stricture, sacciform disease, and the presence of ascarides; but whether it is produced by it has not been determined. We certainly every day see cases of these affections without the occurrence of pruritus. In most of the instances of the latter complaint that have come under my observation I have been disposed to ascribe its origin to some derangement of the digestive apparatus, as dyspepsia and constipation, attended with an irritable state of the constitution, and to regard it as a kind of safety-valve, designed to protect other and more important parts from disease.

In the treatment of this affection, a primary object should be to inquire into the condition of the anus and digestive organs, with a view to the rectification of any disorder that may be supposed to be capable of exerting an influence in producing and perpetuating it. If the general health is impaired, no improvement will be likely to take place in the local disease until this has been restored. In some cases tonics, as iron and quinine, may be demanded, while in others directly opposite measures may be indicated, depending upon the state of the system. In almost every instance a regular systematic course of purgatives, consisting of blue mass or the compound calomel pill, along with iodide of potassium, or, in plethoric subjects, antimonial and saline preparations, in small doses, will be serviceable. In anemic subjects, tincture of chloride of iron, in union with Fowler's solution of arsenic and a minute quantity of bichloride of mercury, is usually highly beneficial. The diet must be bland and unirritant. The most useful topical remedies are the yellow wash, solutions of acetate of lead and laudanum, lotions of permanganate of potassa, and various kinds of ointments, as the zinc, tar, and citrine, the latter greatly diluted. Cold ablutions with castile soap afford marked relief, and are indispensable to the patient's comfort. In obstinate cases, resisting the ordinary remedies, slight pyalism, maintained for several weeks, should be tried.

TRICHIASIS OF THE ANUS.

This affection, which has its analogy in trichiasis of the eye, has not, so far as I know, been before described. As the name implies, it essentially consists in an inversion of the hairs which naturally grow around the verge of the anus, and which, when the inversion is habitual or considerable, often cause a great deal of itching and irritation, either with or without discharge of mucous and other fluids. One of the best examples of this affection that I have ever seen occurred in a middle-aged gentleman on whom I operated many years ago for fissure of the anus. The ulcer was very deep seated, and it was, therefore, necessary to divide the sphincter muscles to their full extent. The wound was long in healing, owing, partly, to his dilapidated health, and partly to the inversion of the hairs around the anus, which had to be repeatedly clipped to prevent irritation.

Some persons seem to be naturally predisposed to this affection, owing to the irregular growth of the hairs around the anus. The trouble will be likely to be much increased when the hairs are unusually numerous, long, and stiff. The true nature of the case can only be determined by careful inspection. The only thing to be done is to trim the offending hairs occasionally with the scissors; but on no account should they be shaved off, as this would be certain eventually to aggravate the complaint by rendering the new growth more stiff and irregular.

When the hair around the anus is very abundant, it may entangle the secretions

of the parts, and even the fecal matter, and thus greatly interfere with cleanliness. The only remedy is frequent ablution with cold water. When the case is complicated with eczema, the occasional inunction of zinc ointment will be of service.

MALFORMATIONS.

The anus and rectum are liable to malformations, of which the most important are, an imperforate state of the former, and the termination of the latter in a cul-de-sac, or its communication with the urethra, the bladder, or the vagina. Examples have been observed, in which the rectum opened in the sacral region, at the umbilicus, on the side immediately below the scapula, and on the face, the congenital vice having, in every instance, been conjoined with other aberrations of structure. In another class of cases, exceedingly uncommon, it terminates in the perineum, in a canal common to it and to the genito-urinary organs, constituting thus a species of cloaca, similar to that of a bird. Cruveilhier has described a case in which the rectum opened under the head of the penis, and a somewhat similar instance in which there was a small aperture, admitting of a flow of feces, in front of the scrotum, has been recorded by Mr. South, of London. On the other hand, the rectum and anus being perfectly natural, the former may receive the ureters, or even the vagina, and thus conduct off both the urine and the menstrual fluid. Such malformations are obviously more interesting in a physiologico-pathological point of view than in a surgical one, inasmuch as they are always necessarily irremediable.

The most simple, as well as the most frequent, variety of imperforate anus, is where the occlusion is effected by a continuation of the common integument, or by a cutaneo-mucous lamina, from one side to the other, the junction being established imperceptibly at the middle line. The covering thus formed is generally so thin and translucent as to permit the meconium to be distinguished through it, and to bulge out whenever the child makes an effort at defecation, the tumor receding under the finger, but immediately reappearing when the pressure is removed. More rarely the closure is established by a cellulo-fibrous structure, from one to three lines in depth, dense, hard, inelastic, and accompanied by more or less contraction, and puckering of the circumjacent parts. In either case, but especially the latter, there is usually an imperfect development of the sphincter muscles; and hence, although the defect may be remedied by operation, the child cannot, for a long time, exercise much control over its alvine evacuations. Sometimes, again, an anus exists, but only in a rudimentary state, being so small and tight as to afford a very inadequate outlet for the contents of the bowels.

When the anus is closed by a covering of the common skin, a crucial incision will generally suffice to afford relief, the angles of the wound being snipped off, and the skin and mucous membrane tacked together by several points of suture. In the second form of the occlusion, the structures must be divided more thoroughly, read-

hesion being prevented by the tent, and the requisite size imparted by the daily use of the bougie. When the anus is merely contracted, the frequent insertion of the mother's finger will be the best instrument for dilating it; this failing, the margins are notched on each side with a probe-pointed bistoury.

Occlusion of the rectum may be caused either by a species of hymen, situated from six to twelve lines above the anus, or by a cellulo-fibrous substance, of variable length and thickness. In the former case, there is always a well-formed anus; whereas, in the latter, the anus is either completely wanting, or present only in a rudimentary state. The ano-rectal septum, as it may be termed, is com-

Fig. 478.



Imperforate Rectum and Anus.

posed of a fold of mucous membrane, of a circular shape, and is always easily detected with the probe or finger. During the cries of the child, and especially during straining, in attempts at defecation, it is sometimes forced down almost within reach of the eye, forming a dusky, fluctuating protrusion. In the second variety of occlusion, of which fig. 478, from Ashton, affords a graphic illustration, the obstruction is caused by fibrous matter, which often extends to the height of an inch, and even an inch and a half, constituting thus a most formidable barrier. Finally, the rectum is sometimes entirely absent, the intestinal tube terminating in a cul-de-sac, or opening, as previously stated, at some unnatural point. However this may be, the pelvis is generally abnormally small, and there is no trace whatever of an anus. In rare cases, the absent canal is represented by a fibro-ligamentous cord, attached to the colon, and descending along the sacrum towards the neck of the bladder, where it is lost in the cellular substance.

The most simple form of occlusion of the rectum admits of relief by a very easy procedure, consisting in a crucial division of the septum, with or without removal of the angles of the wound, and the occasional introduction of the mother's finger, which is, in all such cases, the best bougie. In the other variety, a severe operation is required, and that, too, in many cases, without any certainty of ultimate success. The child being held upon the lap of an assistant, the breech is exposed as in lithotomy, and an incision made through the posterior part of the raphé of the perineum, the knife being carried up in the direction of the curve of the sacrum to the distance, if necessary, of two or three inches, the left index-finger serving as a guide to the instrument. The operation is done slowly and cautiously, care being taken to avoid the bladder and urethra in front, the great pelvic vessels at the sides, and the sacrum posteriorly, lest, as it respects the latter, the knife pass behind the tube of which it is in search. Patency and dilatation are promoted by tents and bougies, cautiously used for a long time afterwards, and aided, if requisite, by an occasional touch of the bistoury, to counteract the tendency to closure, which is always great in such cases.

An operation similar to the one just described may be performed when the rectum is absent, although with hardly any possibility of a successful issue; for, even supposing that the canal could be reached, the child would be likely to perish from peritoneal inflammation, induced either by the incision of the intestine, or by the extravasation of fecal matter. Still, it is justifiable, because there is no other chance of relief, except by the establishment of an artificial anus in the lumbar region; a procedure not only fraught with danger, but, in all respects, so undesirable as hardly to be thought of by any right thinking surgeon, for life, in such a condition, would certainly not be worth having.

The rectum, instead of terminating at the anus, occasionally opens by a narrow canal into the *urinary* passages, generally at the posterior part of the urethra, or at the bas-fond of the bladder, a short distance below the insertion of the ureter; the former mode of communication being the more frequent. The malformation is almost peculiar to males, and generally proves fatal within a few days after birth, on account of the small size of the recto-vesical outlet not allowing of a sufficiently free discharge of fecal matter. To this rule, however, occasionally an exception occurs. Thus, in a case which I attended with Dr. Kempf, and in which I made a very deep incision without reaching the bowel, the child survived six weeks, passing daily a little fecal matter by the urethra. An uncle of the child had lived in a similar condition for upwards of thirty years. Such a vice of formation is generally beyond the surgeon's skill; still, when the danger is imminent, an attempt should be made to reach the bowel by cutting along the sacrum, a staff being inserted, if possible, into the recto-vesical orifice as a guide to the instrument.

When the rectum terminates in the *vagina*, the opening is usually situated low down, and is a good deal larger than when the bowel communicates with the urinary passages, although seldom equal to nature's wants. On this account, and also for the purpose of freeing the vagina, an attempt should be made to establish an opening at the usual site of the anus. The operation is very simple, the knife being carried from before backwards, in the direction of the raphé of the perineum. The skin and mucous membrane may afterwards be tacked together, and reclosure prevented by the finger and bougie. The fissure in the vagina may be obliterated, at a subsequent period, by several points of suture.

CHAPTER XVI.

INJURIES AND DISEASES OF THE ABDOMEN AND ITS CONTENTS.

SECT. I.—WOUNDS AND CONTUSIONS OF THE WALLS OF THE ABDOMEN.

WOUNDS of the muscular walls of the abdomen are, like similar injuries elsewhere, of various kinds, as incised, punctured, lacerated, contused, gunshot, and poisoned. In character they may be simple or complicated; in extent, superficial or deep, small or large; in direction, horizontal, oblique, or vertical. Exhibiting no symptomatological peculiarities worthy of special notice, these different classes of wounds are often of a grave nature, liable to be followed by the worst consequences. Thus, there may be profuse hemorrhage, extensive laceration of the peritoneum, or violent contusion of some of the abdominal viscera, putting life in jeopardy, either immediately or remotely, by shock, exhaustion, or inflammation.

Among the more terrible lesions of this description are buffer accidents, as they are termed, produced by the body being tightly jammed between the buffers of two railway cars. In these accidents the internal viscera, both hollow and solid, are often frightfully contused, lacerated, and even pulpified, without any wound whatever of the muscular walls of the abdomen. The collapse is generally most appalling, and the majority of the patients sink in a few hours, or, at most, in a few days, after the receipt of the injury, without any decided reaction.

Severe suffering and even death sometimes follow the slighter forms of contusions of the walls of the abdomen, either from concomitant injury to the peritoneum or to this membrane and the internal viscera. If the patient does not perish from the immediate effects of the resulting inflammation, his life may be placed in jeopardy secondarily, by the formation of intermuscular abscesses, which, besides being tedious, are always excessively painful, and productive of great constitutional irritation, the more especially as they seldom point, the pus being widely diffused through the sheaths of the tendinous aponeuroses. In persons of feeble, broken health, the most trifling contusion of the abdomen occasionally gives rise to the most extensive abscesses, which no treatment, however judiciously directed, can successfully combat.

The bleeding attendant upon wounds of the abdomen proceeds from various sources, according to the region in which they are situated. In general, it is derived from the epigastric, mammary, circumflex, and lumbar arteries, or some of their principal branches. Usually small and easily controlled, it is occasionally exceedingly profuse and arrested with great difficulty. If the wound is of a valvular form, a large quantity of blood may accumulate immediately beneath the skin, or in the cellular tissue beneath the muscles; forming, in the one case, a diffused bluish swelling, in the other, a hard, circumscribed tumor. Or the blood, instead of collecting externally, may escape into the peritoneal cavity, thus constituting a very dangerous, because a concealed, bleeding. In the latter case, the nature of the hemorrhage will be indicated by a ghastly pallor of the countenance, by cold, clammy sweats, and by great feebleness of the pulse, along with frequent sighing, intense thirst, and excessive restlessness. If the quantity of blood poured out be considerable, it may, as the fluid always has a tendency to gravitate to the lower part of the belly, produce sensible enlargement of the hypogastric region, soft at first, and solid afterwards. Sometimes the hemorrhage is strictly internal, proceeding from a wound of one of the visceral arteries, or, it may be, from one of the large vessels of the abdomen. Such an occurrence is always fraught with danger and perplexity.

Incised wounds of the abdomen, other things being equal, bleed more than lacerated and contused wounds. Punctured wounds sometimes bleed profusely, and the same remark applies not less forcibly to gunshot wounds. In the latter, the hemorrhage sometimes comes on secondarily, from the fifth to the eighth day after the infliction of the injury.

However the bleeding may be induced, or from whatever source it may emanate, the only way to arrest it is to ligate the affected vessel, unless, as may occasionally happen, it is situated favorably for acupressure. Compression applied with an ordinary truss, with the pad resting directly upon the divided parts, should be employed when the hemorrhage cannot be controlled in any other manner. When the bleeding is internal, the outer wound should promptly be enlarged, and the artery secured by ligature.

Muscular wounds of the abdomen must always be treated with the interrupted suture, carried down to within a very short distance of the peritoneum, if, indeed, not through its substance. A very firm hold should be taken of the edges of the breach, otherwise, as the connective tissue is both soft and scanty, the thread will be sure to tear itself out long before the completion of the consolidating process. Moreover, the stitches should be placed very close together. During the subsequent treatment great attention should be paid to position, in order to keep the parts fully relaxed; and, after the patient begins to walk about, the abdomen should be well supported for many months, with a broad gum-elastic bandage, provided with a flat pad. Unless these precautions be properly attended to, ventral hernia will be inevitable.

When matter forms, after these injuries, no time should be lost in evacuating it, since, from the manner in which it is bound down, its retention must be productive not only of great pain and constitutional disturbance, but of extensive disorganization of the walls of the abdomen. The incisions for this purpose should always be ample, and care should be taken that they are not made in the situation of the epigastric artery.

SECT. II.—WOUNDS, CONTUSIONS, AND INFLAMMATION OF THE PERITONEUM.

Wounds of the peritoneum do not differ, in regard to their essential features, from wounds in other parts of the body. However induced, their danger is due not so much to the injury inflicted upon this membrane itself as to the mischief sustained by the abdominal muscles and viscera, the latter of which seldom entirely escape in any case. As a general rule, it may be stated that the probability of a fatal result will be greater, other things being equal, in gunshot, contused, and lacerated wounds of the peritoneum than in the simple incised, unless they are of extraordinary extent, as happens, for example, in practising the large incision in ovariectomy, the mortality from which is sufficiently great.

Mere contusions of the peritoneum sometimes induce violent and even fatal inflammation, especially in elderly, broken-down subjects. Such accidents are most liable to be produced by falls, blows, kicks, and similar injuries; but they may also be caused by partially spent cannon balls and pieces of shell, by the passage of the wheel of a carriage, and by the body being forcibly compressed between the buffers of a railway car. Lesions of this description are often complicated with similar lesions of the abdominal muscles and viscera, along with extensive extravasations of blood, both external and internal, and yet the most careful inspection may fail to discover any external marks of mischief, the integument having safely glided away from the vulnerating body.

Laceration of the peritoneum, more or less grave in its character, may be caused by external injury, as a blow or fall. It has also been known to be produced in leaping and during the violent throes of parturition. In old, decrepit subjects, laboring under habitual constipation, the serous covering of the intestines occasionally gives way during defecation, as in the interesting cases observed by Rostan in the old women at La Salpêtrière at Paris. A similar effect sometimes ensues from a twist of the bowel, mechanically interfering with the transmission of its contents.

Laceration of the peritoneum, unless extensive, or complicated with serious lesion of other structures, is not, in general, to be regarded as very dangerous, as it usually readily yields to appropriate treatment. When the accident is accompanied, as it occasionally is, by profuse hemorrhage, consequent upon the rupture of a large vessel, it may, of course, terminate fatally, perhaps promptly, and even without any effort at reaction, the patient looking ghastly pale, and the abdominal cavity being filled with blood. It has been asserted that a wound or rent of the peritoneum may lead to fatal hemorrhage, but such a statement is not borne out by facts, as any one may satisfy himself by taking into view the small size and great paucity of the vessels of this membrane.

In the treatment of these injuries the great and leading indication is to control the resulting inflammation, pointed out in the remarks on peritonitis. When excessive prostration exists, stimulants, as wine and brandy, with ammonia, may be necessary from the commencement.

Traumatic Peritonitis.—All injuries of the peritoneum must necessarily be followed by a certain degree of inflammation of its substance, and the amount of this may be just sufficient, on the one hand, to enable nature to effect the work of repair, or, on the other, it may be so severe as to cause intense suffering, if not speedy dissolution. The inflammation may be acute or chronic, partial or general. The acute form of the disease usually runs its course very rapidly, and is always attended with more or less fever, commonly ushered in by chilly feelings, or even violent rigors. Pain and soreness of the abdomen, increased by the slightest movement and pressure, are early effects; the patient lies upon his back, and retracts his limbs, in order to relieve the tension of the abdominal muscles; the breathing is hurried, short, and thoracic; the pulse is small, hard, and wiry, beating from 120 to 140 in the minute; the tongue is coated; the bowels are tympanitic and constipated, or alternately constipated and relaxed; the stomach is nauseated, and rejects its contents; the thirst and restlessness are intense; there is an urgent desire for cold air and cold drink; the urine is voided with great difficulty; there is extraordinary insomnia; the eyebrows are knit; and the countenance is expressive of great suffering. As the case progresses, the system becomes rapidly exhausted; the stomach relieves itself, not by vomiting, but by regurgitation; the pulse is creeping and almost imperceptible; the extremities are cold; the surface is covered with a clammy sweat; hiccup and twitching of the tendons supervene; and death soon closes the scene. In the earlier stages of the disease, a distinct friction sound, the result of a deposit of lymph, is sometimes detectable on auscultation of the abdomen; while, in the more advanced stages, there is, occasionally, marked fluctuation, due to an effusion of serum. When suppuration takes place, the suffering is always greatly increased in intensity, and the system rapidly gives way under its exhausting influence. Similar effects are invariably produced when the disease has been induced by the extravasation of fecal matter, whether occasioned by a wound of the bowel or ulcerative perforation. The pain is then of the most agonizing character, sharp, lancinating, or pricking, and speedily causes fatal collapse, the patient often dying in from twenty to thirty-six hours from the commencement of the attack.

Although such is the usual course of this disease, there is occasionally an instance in which the symptoms are so imperfectly marked as to entitle it to be termed latent. The occurrence, which is always one of peculiar danger, from its liability to be overlooked, is most common in feeble, anemic subjects, exhausted by previous suffering, in persons who have been greatly reduced by shock and loss of blood, and in patients who are laboring under some other and more severe disease which, for the time, masks the peritoneal. Under such circumstances, error can only be avoided by a most thorough examination, special attention being paid to the state of the countenance, the pulse, the abdomen, the respiration, and the patient's posture.

Chronic peritonitis often comes on in a very insidious manner. The symptoms are generally comparatively mild. The abdomen is sore and tender, rather than painful; the pulse is hard and frequent, but more full than in the acute form of the disease; the stomach is less irritable; the bowels are relaxed, instead of being constipated; and there is little, if any, tympanites. Among the more constant phenomena are, progressive emaciation, more or less nausea, and a habitually wrinkled condition of the forehead and eyebrows.

Peritonitis is always a dangerous disease. The partial form is often recovered from; the general, seldom. When the attack has been caused by fecal extravasation, death is inevitable. Suppurative peritonitis is almost invariable fatal; and the danger is also great when there is an unusual effusion of serum, or serum and lymph.

The *treatment* of acute peritonitis is sufficiently simple. The first and most important indication is to place the system under the influence of opium, for the three-fold purpose of allaying pain, inducing sleep, and preventing peristaltic action of the bowels. To effect these important objects, opium should be given in full and sustained doses, as two or even three grains twice or thrice in the four-and-twenty hours. The rule is to keep the bowels thoroughly locked up either until the patient dies or the disease is conquered. If suffering is experienced from flatus, a turpentine and asafoetida enema will generally afford prompt and decided relief, but all laxative

medicine by the mouth must be scrupulously interdicted. Blood is freely taken from the arm, if the patient is plethoric, and, in all cases, by leeches from the abdomen. Hot anodyne fomentations are used; the abdominal muscles are relaxed by elevating the shoulders and placing pillows behind the knees; thirst and nausea are controlled with ice, champagne, and the effervescing draught; and the system is sustained with beef essence and animal broths, all solid articles being carefully avoided. The injection into the rectum, every few hours, of strong meat soup, as recommended by Dr. Anstie, has been found highly useful in allaying pain and gastric irritability. No special benefit will be likely to result from the exhibition of calomel, except as a corrective of the secretions; and as to vesication of the abdomen, I have seldom found it to be of any advantage, especially in the more severe forms of the disease. In chronic peritonitis, on the contrary, it is generally more trustworthy than any other local means, while great benefit may be expected from the use of calomel in small doses, combined with opium, and repeated thrice or four times in the four-and-twenty hours. When there is a great accumulation of serum, no time should be lost in evacuating it with the trocar, as the tendency of the fluid, if retained, is to empoison the system. The adhesions of the intestines, consequent upon a deposit of lymph, are best treated with mercurial inunctions and the exhibition of iodide of potassium in combination with bichloride of mercury.

SECT. III.—WOUNDS OF THE STOMACH AND INTESTINES.

1. *Wounds of the Stomach.*—Wounds of the stomach are characterized by excessive pain in the epigastric region, nausea, extreme prostration, and vomiting of blood, either pure or mixed with bile, mucus, or ingesta. The site of the external wound will often throw important light upon the diagnosis. The great danger is from effusion of the contents of the stomach, causing peritonitis. If the opening is small, situated at the lesser curvature of the organ, and inflicted during the empty state of the stomach, restoration may take place by the first intention; in general, however, such a result is not to be looked for, and in most cases death occurs, as in similar lesions of the intestines, in from thirty-six to forty-eight hours, from inflammation. Occasionally the patient dies from shock. Wounds of the stomach are often complicated with copious hemorrhage, and with injury of the diaphragm, lungs, bowels, and other viscera. In some instances, the patient escapes with a fistulous opening in the epigastric region, as in the celebrated case of Alexis St. Martin, so well described by Dr. Beaumont.

Hevin and Plouquet have collected a number of examples of recovery in wounds of this organ, inflicted by various kinds of weapons, as knives, swords, bayonets, and firearms. Thomson has recorded two similar cases which occurred after the battle of Waterloo; the injury in one having been inflicted by a pike, and in the other by a musket ball.

Rupture of the stomach is sometimes induced by a blow, fall, or kick; and the cases in which death is caused by external injury without rupture are by no means uncommon. Many years ago I saw a man who instantly expired from a blow inflicted upon the epigastrium with a fist. The records of surgery abound in similar examples. No perceptible lesion is usually discoverable in such cases on dissection.

Wounds of the stomach must be closed by suture, and afterwards managed with special reference to the prevention of undue inflammation. For the first few days nothing should be taken but mashed ice, in quantities barely sufficient to allay thirst and to quiet gastric irritability, with, occasionally, a little arrowroot, tapioca, or beef essence. When gastrorrhaphy has been neglected, or rendered impracticable, it is best to withhold everything by the mouth until the edges of the wound have contracted adhesions to the adjacent parts, and to place our main reliance, as it respects the comfort and support of the patient, upon the application of ice to the epigastrium and the use of nourishing enemata. Laxatives are, of course, out of the question. Constipation and flatulence are relieved by injections; pain and vomiting, by morphia.

2. *Wounds of the Intestines.*—Wounds of the intestines are of three kinds, incised, lacerated, and punctured, including under the latter denomination all lesions from firearms and pointed weapons, as dirks, sabres, bayonets, and swords. The parts most liable to suffer are the ileum and the jejunum, their great length, their floating condition, and the large space over which they are spread in the

abdomen rendering them peculiarly subject to injury. The bowel alone may be injured, or the same blow may pierce the omentum, spleen, liver, or other organs. Sometimes an important bloodvessel is laid open, thus complicating the case with hemorrhage. When the lesion is inflicted with a ball, both the small and large bowel are often involved. The same circumstance not unfrequently happens in wounds made with knives, dirks, and other sharp-pointed weapons. Again, the tube may be merely pierced by the vulnerating body, or it may be completely transfixed, either on the same level, or at different heights. In 1854, I attended a man, along with Dr. Cummings, in whom a pistol ball, entering a short distance below the navel, a little to the left of the middle line, completely perforated, in its upward and outward passage, the ileum, jejunum, duodenum, and arch of the colon, making thus eight separate orifices. Finally, instances occur in which the bowel is torn completely across, as when the injury is inflicted by a severe fall, by compression of the body, or by the kick of a horse. In a case reported by Dr. Lidell, the ileum was fatally ruptured by the kick of a woman. Such accidents may occur without any external marks of the injury.

Wounds of the intestines are of various forms. In general, they are oblique, but occasionally transverse, or even longitudinal. Gunshot wounds are usually somewhat circular. In their dimensions, these lesions vary from the smallest puncture to an opening several inches in length.

Symptoms.—The symptoms of these injuries are local and constitutional. Both, unfortunately, are too often equivocal, especially within the first few hours after the receipt of the wound, when there is no protrusion of the bowel, or when the opening in the wall of the abdomen is so small, so situated, or so shaped as to oppose an effectual barrier to the escape of the contents of the tube. When the intestine hangs out at the external wound, the nature and extent of the mischief are at once apparent. But it is very different when the bowel is retained in the belly. In such an event, the most important sign is an escape of feces, bile, mucus, ingesta, or fetid air in the opening in the wall of the abdomen. As these substances can proceed only from the alimentary canal, the stomach, or the gall-bladder, their presence is characteristic.

When the wounded bowel does not protrude, there is usually, at an early period after the receipt of the injury, a development of tympanites, evidently due to an escape of gas into the general peritoneal cavity, causing a hollow, drum-like sound on percussion, with tenderness on pressure, and difficulty of respiration. The distention is sometimes enormous, and, as it is often present when the other symptoms above mentioned are absent, it is an occurrence of great diagnostic value. Instances are met with in which the gas escapes from the wounded intestine into the subperitoneal cellular tissue, and thence among the muscular and subcutaneous structures of the wall of the abdomen, where, diffusing itself more or less extensively, it forms a puffy, crepitating swelling, easily distinguishable by sight and touch. A discharge of blood from the anus is occasionally observed, and is a symptom of some value. Shock and pain are always present. The countenance is deadly pale, there is nausea, either alone or accompanied with vomiting, the pulse is small and tremulous, the breathing is feeble and embarrassed, the mind is bewildered, there is frequent sighing with excessive restlessness, and a constant desire for cold air and drink, griping pain is complained of, and, in the more severe cases, there is a remarkable tendency to syncope and alvine evacuations with a sense of extreme prostration. The pain and shock are always excessive when there is fecal effusion into the peritoneal cavity.

Wounds of the bowels are liable to be complicated with hemorrhage, from lesion of the vessels of the abdomen. A considerable quantity of blood sometimes flows back into the cavity of the peritoneum from an opening in the epigastric artery, but most commonly the bleeding proceeds from injury of the omentum, the mesentery, or some other structure, accidentally divided along with the intestine. In gunshot, sabre, and dirk wounds the hemorrhage may be derived from the aorta or vena cava. However this may be, unless the outer opening is unusually large, very little blood will appear externally, so as to disclose the true nature of the case; instead of this, it will pass back into the serous cavity, lodging in the folds of the bowel, descending into the pelvis, or diffusing itself extensively among the viscera. The existence of this form of hemorrhage is denoted by excessive pallor of the

countenance, a small, tremulous state of the pulse, frequent sighing, clammy sweats, coldness of the extremities, intense thirst, and constant jactitation.

Diagnosis.—In the diagnosis of a wounded bowel, important information may frequently be obtained, in regard to the direction, extent, and depth of the lesion, by a careful consideration of the size and shape of the vulnerating body, and the relative position of the parties at the time of the accident. If the opening in the wall of the abdomen is large, the best instrument for ascertaining its condition is the index-finger, or a grooved director; with either of these it is generally easy to determine whether the wound involves the muscles only, or the muscles and the peritoneal cavity. The pocket-probe is not well adapted to such an examination, as it is liable, from its small size, to have its point arrested among the tissues. Whatever instrument be employed, all officious interference must be avoided, as likely to do harm instead of good. In exploring the wound, it is important that the part and body should be placed as nearly as possible in the position in which they were at the moment of the accident. When the injured bowel protrudes at the external opening, the diagnosis is at once obvious, as the nature and extent of the lesion may be determined by simple inspection. The lesion, in the absence of pathognomonic symptoms, ought to be suspected when nausea and vomiting occur after a penetrating wound of the abdomen, accompanied with griping pains, great debility and faintness, jactitation, extreme anxiety, and cold sweats. The case is plain enough when there is a discharge of the contents of the alimentary tube, or a sudden development of tympanites, gradually increasing, and attended with decided tenderness of the abdomen.

Effects.—It is an interesting fact that, although an instrument may pierce the peritoneal cavity, it need not necessarily wound the bowels, or, indeed, any other important organs. Nay, further, it may not only lay open this cavity, but completely traverse it, or even emerge at the opposite side, and yet inflict no serious mischief upon the contents of the abdomen. Instances like the latter are certainly uncommon, but that they do occasionally occur is abundantly proved by the concurrent testimony of military and civil practitioners.

That the extravasation of fecal matter is greatly influenced by the direction and extent of the wound, I ascertained long ago by numerous experiments performed upon dogs. I found, for example, that, when the opening is six lines in extent, whether transverse, oblique, or longitudinal, there is almost invariably an escape of fecal matter, speedily followed by fatal peritonitis. If, however, the wound, whatever may be its direction, does not exceed four lines in length, or a third of an inch, such a contingency will not only be less likely to happen, but in many cases, if not in a majority, nature, aided by appropriate therapeutic measures, will be fully competent to effect restoration.

The safety of the patient, in comparatively small wounds of the bowels, no doubt frequently depends upon the diminution which the opening instantly experiences after their infliction, from the contraction of the muscular fibres of the tube, and the eversion of its mucous membrane, as seen in fig. 479. The following experiments bear directly upon this point: 1. A longitudinal incision, two lines and a half in length, immediately contracted to one line and three-quarters, with a sufficient degree of eversion of the lining membrane to close the resulting orifice. 2. A similar wound, four lines long, diminished in a few seconds to three lines, by one line and a half in width; it assumed an oval shape, and the mucous tunic protruded on a level with the peritoneal surface, leaving no perceptible aperture. 3. An oblique cut, seven lines in length, contracted to five, by two and a half in width, with marked eversion of the lining membrane. 4. A transverse wound, two lines and a half long, was reduced almost instantaneously to two lines in diameter; it was of a rounded form, and the two outer coats of the bowel retracted so as to expose the mucous tunic. 5. In this experiment, in which the incision, likewise transverse, was half an inch in extent, the orifice assumed a rounded, oval shape, and was reduced to four lines, by two and a half in width, the internal coat exhibiting, as in the other cases, a pouting or everted arrangement.

These observations are of the deepest interest, as showing the efforts which nature

Fig. 479.



Wound of the Intestine, with Eversion of its Edges.

makes to close a breach of this kind, almost the very instant it is inflicted. The eversion of the mucous membrane forms a constant and striking feature in all incised wounds of the bowel, of whatever shape, extent, or direction, and may be compared, in its effects, to the contraction and retraction of the extremities of a divided artery. As the latter are intended to prevent the effusion of blood, so the former is intended to oppose the effusion of fecal matter.

In gunshot wounds of the bowels, and in incised wounds attended with severe contusion, the eversion of the mucous coat is generally very slight, and sometimes even absent. Owing to this circumstance, wounds of this description, even when very small, are extremely prone to be followed by fecal extravasation and fatal peritonitis.

The extravasation of fecal matter generally produces inflammation of the peritoneum within a very short time, probably within less than an hour, after its occurrence. The disease, once begun, progresses with great rapidity, and often extends over nearly the whole surface of the membrane. The symptoms, denotive of its presence, are, violent burning pain of the abdomen, with exquisite tenderness on pressure, and retraction of the thighs; constipation of the bowels; a sharp, frequent, and contracted state of the pulse; intense thirst; constant wakefulness; excessive restlessness; great anxiety; and coldness of the extremities. In the latter stages, there is generally some degree of nausea, with occasional vomiting; the pulse is weak and fluttering; the surface is bathed with a cold, clammy sweat; the features are collapsed; the breathing is oppressed and laborious; the belly is extremely tense and tumid; the strength rapidly declines; and, finally, the patient dies under all the symptoms of one sinking from the effects of mortification. The attack, as previously stated, rarely continues beyond two days and a half, and often terminates in a much shorter period. The appearances after death are always well marked, even when the disease has not been protracted. The peritoneal surface is highly inflamed, the bowels are covered with lymph, and the abdominal cavity usually contains a small quantity of turbid serum. Occasionally a considerable amount of pure blood, or blood mixed with lymph and other substances, is present. At the seat of the wound, and frequently also at other points, fecal matter, or other evidence of intestinal effusion, is found. The edges of the opening are usually somewhat everted, and adherent to the surrounding parts, which are always extremely red and inflamed. Extensive adhesion generally exists between the bowels, as well as between the bowels and other structures; and, on penetrating the belly, there is almost invariably a free escape of fetid gas.

Prognosis.—The danger in wounds of the intestines is always very great, even when the opening is of very small extent. The most common causes of death are shock, hemorrhage, and peritonitis; the latter being almost inevitably fatal whenever there is the slightest fecal extravasation. A mere contusion of the bowel, however slight or circumscribed, may occasion destructive inflammation. Gunshot wounds are especially dangerous, particularly when the missile perforates the tube in a number of places. Yet, even in such a condition, a person may occasionally live for a number of days, as in one of my patients, a man, twenty-two years of age, who survived a pistolshot nearly one week, notwithstanding that there were eight openings, involving the ileum, jejunum, duodenum, and the arch of the colon. A wound of the large intestine is, as a rule, less dangerous than one of the small, owing, apparently, to its more fixed position and the more solid nature of its contents. During the late war, a very considerable number of cases of gunshot injuries of the large bowel were recovered from, whereas most of those involving the small proved fatal.

Mode of Repair.—Wounds and punctures of the bowel, unaccompanied by an effusion of fecal matter, heal, if left to themselves, either by the adhesion of their edges to the surrounding parts, or by a deposit of lymph upon their surface, and the gradual approximation of their lips. In the majority of cases, it is probable that the repair is effected in the former manner, inasmuch as there is always a great tendency in the injured structures to attach themselves to those in their immediate vicinity. Even wounds of large size are occasionally cured in this way. In some instances, again, the breach is closed by a piece of omentum, which, projecting into it, fills it up like a tampon. When this occurs, the contiguous serous surfaces become firmly adherent to each other, and that portion of the plug which lies within the bowel, and assists in maintaining its continuity, is eventually absorbed; a circumstance which leads to the gradual approximation of the lips of the wound, and their ultimate reunion.

The mucous portion of the wound always heals with difficulty, first, because it naturally furnishes lymph very sparingly, and, secondly, because it is constantly in contact with feces, bile, and other heterogeneous matter, interfering with the process of repair. It is generally only after a long time that the edges are flattened down, and that the breach is finally closed. Occasionally the cure is effected by granulation, as I found in a number of my experiments upon dogs.

When the wound is sewed up, the mode of repair is essentially the same, whatever may be its form. The inflammation which is lighted up induces an effusion of lymph, which is speedily followed by the adhesion of the injured coil to the neighboring structures, among which it is sometimes completely buried. At other times no such adhesion occurs, but the affected part throughout the entire line of the suture is coated with a layer of plastic substance, by which the continuity of the serous membrane is finally reestablished, and the threads used in sewing up the wound are concealed from view. In dogs, there is, in a great majority of cases of this injury, an attachment of the omentum to the surface and edges of the wound, as seen in fig. 480, which thus remarkably assists in the process of restoration; but it is rarely, according to my experience, that we witness such an occurrence in the human subject, owing, perhaps, to the fact that the omentum is so much smaller in man than in the canine race of animals.

The manner in which the ligatures used in sewing up a bowel are detached varies, according to the mode in which they are applied. Both in the interrupted and the continued sutures, with their different modifications, the threads, if cut off close to the surface of the wound, always fall into the interior of the canal, along with the contents of which they are afterwards evacuated. The reverse is, of course, the case when the ends are brought out at the abdominal opening. The period at which the detachment of the ligatures occurs varies, on an average, from ten days to several weeks. In dogs, I have frequently found them still firmly adherent at the end of a month.

Treatment.—From what has been said, it is evident that the great danger in this class of injuries is from fecal effusion, so liable to occur even when the wound is comparatively insignificant. The proper treatment, therefore, to be pursued is simply to sew up the wound, and to replace the bowel as speedily as possible, watching the case most assiduously afterwards, with a view of preventing undue peritoneal inflammation; for, whenever this obtains the ascendancy, the patient must necessarily perish. It is folly to think of any other practice; the sheerest nonsense to talk about the irritating nature of intestinal sutures. Enterorrhaphy is, in itself, one of the most innocent of operations, and it is only surprising that it should ever have been regarded in any other light. What possible harm can result from depositing a little thread in the coats of an intestine, and retaining it there for ten or a dozen days? Some inflammation must, of course, arise, but this is precisely what is needed for the safety of the patient and the cure of the wound. Even if the wound is not more than a line and a half in length, the bowel ought not to be returned without stitching it. Fecal extravasation might occur, and the patient should, therefore, not be subjected to the risk of such a contingency. In several of my experiments death was produced, not by sewing up the bowel, or by the manipulation employed in performing the operation, but by the escape of fecal matter, along the large interspaces between the sutures, which thus allowed the wound to gap, and to favor the occurrence in question. Indeed, it may be laid down as an axiom that, whenever the closure of the wound is incomplete, there is danger of intestinal effusion.

There are only two sutures which, in my opinion, are at all suitable for sewing up a wound of the intestines. These are the continued and the interrupted, with the modifications of the latter proposed by Lembert and Gely. All other expedients of this kind are complicated, uncertain, and, therefore, inapplicable. The continued

Fig. 480.



Wounded Bowel with Adherent Omentum.

and interrupted sutures are easily executed with a long, slender cambric needle, armed with a small but strong and well waxed silk thread.

The *continued* suture, fig. 481, is made by passing the needle from one side of the wound to the other, across all the tunics of the bowel, except the mucous, in such a manner as to bring the serous edges in the most accurate apposition. Each stitch should not include more than half a line of substance, and the ends of the thread, being well secured at each angle of the opening, should be cut off close to the surface of the tube. In the interrupted suture, the needle is introduced in the same manner

Fig. 481.



Continued Suture.

Fig. 482.



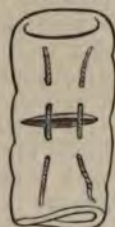
Ligature Partially Detached.

as in the continued, the ligatures being placed about two lines apart, but none being tied until all have been applied. The ends are then secured with a double knot, and cut off close. As the sutures become detached they gradually pass into the intestinal tube, into which they finally drop, to be discharged along with the fecal matter. In the adjoining sketch, fig. 482, the ligature is seen to be partially separated.

In *Lembert's suture*, fig. 483, which I have often employed very successfully upon dogs, a short stitch, including only the peritoneal and muscular coats, is taken on one side of the wound, about two lines and a half from its edge; the needle is then carried across the gap, and a similar stitch is taken on the opposite side. In this

way one thread after another is deposited, the intervals between them not exceeding the sixth of an inch; and when they are all arranged, they are drawn firmly together, and tied with a double knot, the ends being cut off as in the ordinary operation. By this procedure the wound is completely closed in every portion of its extent, its lips being inverted so as to approximate their serous surfaces, at the same time that they form within the tube a ridge, upwards of a line in length.

Fig. 483.



Lembert's Suture.

Fig. 484.



Gely's Suture.

Gely's suture, which is merely a modification of that of *Lembert*, is made with two needles inserted near the angle of the wound, about one line from its edge; they are then carried along the interior of the bowel, parallel with the wound, for the sixth of an inch, when they are brought out precisely at the same level, so as to appear again on the peritoneal surface. The threads are then crossed, the right needle being passed through the puncture made by the left, and conversely, when the ends are firmly tied, and cut off close as in the ordinary operation. The number of sutures varies, of course, according to the extent of the cut. In this way the edges of the wound are thoroughly inverted, and, consequently, all danger of fecal effusion is prevented; the coaptation, in fact, is so accurate as to conceal the ligatures. The annexed cut, fig. 484, conveys a correct idea of the manner of practising this suture.

In small wounds, of whatever direction, a decided preference ought, in my opinion, to be given to the ordinary interrupted suture. It is easy of execution, and, if proper care be taken in placing the stitches, the most perfect closure may be effected with

t, even as it respects the serous edges of the wound. Of Lembert's modification of this method, I have also a favorable opinion, although it is more complicated, and more liable to be followed by undue contraction of the bowel at the seat of the injury. When the wound is of unusual length, the continued suture will be the most suitable, as it admits of easier application, and is attended with less risk of fecal extravasation. When the opening amounts to a mere puncture, its edges may be included in a ligature, as is occasionally done in the operation for strangulated hernia.

The wound being closed, and any dirt, blood, or fecal matter that may be present thoroughly removed, the next step is the reduction of the bowel, which is effected upon the same principle as in the operation for strangulated hernia. If the tube be tightly girt, the external opening must be dilated with the probe-pointed bistoury, a very small incision generally sufficing for the purpose. When the bowel is greatly distended with gas, causing difficulty of reduction, a few little punctures may be made in the tube, but this must be done with unusual care. When the bowel and omentum are protruded together, the former should always, as a general rule, be replaced first. When the omentum is inflamed and swollen, as usually happens when it has not been promptly restored, the best plan is to cut off the affected portion, and, after having tied any bleeding vessels that may have been divided, to replace the parts; a procedure far preferable to allowing it to remain, as is sometimes advised, in its unnatural position.

In the attempts at replacement, it is very important to know that the bowel has actually slipped into its natural situation. If the external wound is very devious, or if the peritoneum has been detached from its inner edges, a portion of the tube might be retained on the outside of the serous cavity, and thus experience all the bad effects of strangulation. To guard against such a contingency, the surgeon should not rest satisfied until he has assured himself that the passage is perfectly free, and that his finger has been fairly within the abdomen, in contact with the convoluted surface of the bowel.

The external wound is carefully closed with the twisted suture, made with a stout pin carried through the muscular walls of the abdomen in such a manner as, if possible, to embrace the edges of the peritoneum. Unless the deep portion of the wound be properly united, the occurrence of hernia will be inevitable. A compress and a broad bandage complete the dressing.

It is still a mooted question as to what should be done when the wounded bowel does not protrude at the opening in the wall of the abdomen. When we reflect upon the fact that in all lesions of this kind the great danger is from fecal effusion, and that such effusion is almost inevitable even when the opening of the intestine is of very small extent, the duty of the surgeon, I think, plainly, is to enlarge the abdominal orifice, to seek for the wounded tube, and to sew up the cut in the usual manner. Such a procedure, promptly and efficiently executed, while it holds out the only possible chance of safety, would not place the patient in a worse condition than a woman who has undergone the Caesarian section, or a person whose abdomen has been ripped open by accident; recovery from both of which, as is well-known, is by no means infrequent. The truth is, the fatality of penetrating wounds of the abdomen has been greatly exaggerated; and hence a degree of prejudice has arisen against this practice so deeply rooted as to render it almost impossible to surmount it by any course of argument, however well founded. These remarks are more especially applicable to incised wounds. In gunshot wounds no benefit, it seems to me, would be likely to accrue from such a course of treatment, as the bowel is generally pierced in a number of places, and the case, on this account, must, therefore, generally be fatal.

During the after-treatment the patient should be watched with the greatest possible care and assiduity. The abdominal muscles must be maintained in a state of constant relaxation; and, as the great danger after all accidents of this kind is from peritonitis, the bowels should be kept effectually locked up with anodynes for the better part of a fortnight, or, indeed, even longer, peristaltic motion being prevented at all hazard, as the only means of safety. After the first few days, flatus may be relieved by means of an enema of cold water, or, what is preferable, of turpentine and asafetida. All laxatives, even of the mildest and most gentle character, are utterly inadmissible during the first few weeks. The urine should be drawn off regularly with the catheter. The diet should be entirely fluid, and used in as concentrated a

form as possible. If peritonitis should arise, the most suitable remedies will be the abstraction of blood by the lancet and leeches, blisters, and anodyne fomentations. When, as sometimes happens, the abdominal cavity becomes distended with serous, sero-plastic, or sero-purulent fluid, riddance must be promptly effected with the trocar, for the twofold purpose of relieving the viscera of undue pressure, and of preventing the absorption of deleterious matter. Such a procedure, provided there is not too much exhaustion, will greatly facilitate recovery. During convalescence, as well as for a long time afterwards, the abdomen must be well supported, to prevent hernial protrusion at the seat of the external wound, and the greatest attention must be paid to the diet and bowels.

SECT. IV.—GUNSHOT INJURIES OF THE ABDOMEN.

Gunshot wounds of the abdomen offer few peculiarities apart from those of ordinary injuries. When the missile penetrates the muscular walls of this cavity, it generally inflicts irreparable mischief, even when it does not enter any important viscus, simply by exciting violent inflammation of the peritoneum. Indeed, fatal disease of this membrane is not unfrequently induced by the contusion merely which it experiences from the blow of a ball or shell, without any actual wound of its substance. Gunshot lesions of the stomach, intestines, spleen, liver, gall-bladder, kidneys, and urinary bladder, are nearly always fatal, death being caused either by shock, by shock and hemorrhage, by hemorrhage alone, or by inflammation usually supervening within a few hours after the accident, and rapidly tending to destruction, despite the best-directed efforts of the surgeon. A bullet occasionally traverses the abdomen completely without inflicting any serious injury upon its contents. Guthrie relates the case of a soldier, whose abdomen was transfixcd by a ramrod, entering two inches below the umbilicus, and emerging at the second lumbar vertebra, followed by recovery without any untoward occurrence. A similar example, observed by Dr. Throop, is recorded in Professor Hamilton's Treatise on Military Surgery. Last summer I saw with Dr. Allaband a girl, sixteen years old, whose abdomen had been transfixcd a few hours previously by a ramrod, which, entering nearly midway between the pubes and umbilicus, a little to the left of the middle line, passed through the iliac bone, and emerged a short distance above the hip-joint. Great force was required to extract the ramrod. No gas or fecal matter escaped at either opening of the wound. In this case death occurred at the end of the sixth week from peritonitis.

In order to exhibit the nature and effects of these lesions in a more tangible light, I shall subjoin here, in a modified tabular form, the returns of the wounded, as given in the Medical and Surgical History of the British army, in the Crimea.

1. Simple flesh wounds and contusions	{ Slight	43		43	
	{ Severe	73	18	37	24
2. Penetrating the abdomen and lodging, with lesion	{ Not accurately known	14	13		1
	{ Of peritoneum only	3	8		
	{ Of viscera	101	95	1	5
3. Rupture of viscera without external wound		4	4		
4. Fracture of pelvic bones without penetration of the abdomen		29	16	5	8
Total		266	149	86	38

Of the above cases there were 23 in which the missile lodged, with a mortality of 21, and 63 in which it did not lodge, with a mortality of 60. Thus, it will be perceived that, in gunshot wounds of the abdomen, with penetration of its cavity, death was the rule, and recovery the rare exception. The cause of death in these cases was usually shock, with or without hemorrhage, the great majority expiring within the first twenty-four hours after the receipt of the injury. A very small proportion of the cases perished from peritonitis.

It not unfrequently happened in the above cases that several viscera were wounded by the same missile. "Thus, in one instance, the liver, spleen, and pancreas were injured by the same bullet; in another, the liver and kidneys; in another, the pancreas, stomach, and colon; in many, the small intestines and urinary bladder, the men having been shot from above." In a soldier of the 19th regiment, a musket-ball entered near the umbilicus and issued near the sacrum, perforating the small bowel at sixteen points, the man being at the moment in the act of defecation. He survived his wounds nineteen hours.

Of 37 cases of penetrating gunshot wounds of the abdomen, reported by Alcock, Legouest, and Menière, only one was saved. Of 31 cases that occurred in the Indian wars 32 died and 6 recovered. In the expedition against Constantine every one that was thus injured perished, and the same bad luck attended those that were wounded at the siege of Moulton.

Of 2164 flesh wounds of the abdomen reported in circular No. 6, as having occurred during our late war, 114, principally cases of sloughing after injuries by shell, were fatal; while of 414 penetrating wounds, in which the results had been ascertained, 308, or 74 per cent., were mortal. In many instances fecal fistules ensued, but they usually closed without operative interference.

Gunshot lesions of the walls of the abdomen present the same characters as similar injuries in other muscular regions. Erysipelas is a common effect, and they are occasionally followed by tedious abscesses, the matter forming in the track of the missile and producing, if not speedily evacuated, extensive havoc among the surrounding structures.

Of the symptoms, diagnosis, and treatment of these accidents nothing need be said here, as these topics are fully discussed in the preceding section.

Frightful injury and even death sometimes follow shell wounds and grazes by round shot with little, if any, apparent mischief of the surface of the abdomen. A case which occurred at Sadoolapore affords an excellent illustration of the nature of such an accident. A man was struck by a round shot on the right arm and chest, with the effects merely of a bluish spot on the former, and hardly any visible mark on the latter. He expired at the end of twenty hours, without having rallied from the shock. The peritoneal cavity was filled with dark blood, and the right lobe of the liver was torn into small pieces, some of which were quite loose. The other viscera were healthy, and there was no evidence of inflammation.

SECT. V.—FOREIGN BODIES IN THE STOMACH AND BOWELS.

Foreign bodies, varying much in their character, occasionally descend into the stomach, and, becoming arrested there, cause great distress, and sometimes even death. Jugglers in the exercise of their profession and persons intent on self-destruction are, perhaps, the most common subjects of such accidents. A few years ago a man in Iowa, in performing some tricks at legerdemain, allowed a bar of lead, ten inches long, by upwards of six lines in diameter, and weighing one pound, to fall into the stomach. The usual symptoms are, violent pain in the epigastrium, extending about in different directions, a sense of weight and obstruction in the stomach, nausea, and constipation of the bowels. The patient is generally able to walk about, and even to attend to business, especially during the first few days after the introduction of the extraneous body.

The manner in which these substances are disposed of varies. Pieces of bone, cartilage, pins, needles, and coins, often pass into the bowels, and are finally discharged along with the feces. When the body lodges, and is productive of pain and danger, extrusion must be effected with the knife, the place of incision being regulated by the site of the intruder, which may often be distinctly felt through the walls of the abdomen. In the case above alluded to, Dr. Bell, of Davenport, removed the bar of lead by making an incision, four inches in length, from the umbilicus to the false ribs, some distance beyond the middle line. The opening made in the stomach was just large enough to admit of the passage of the bar, and required no sutures, as it became immediately closed by the contraction of the muscular fibres of the organ. The external wound was stitched in the usual manner. The man recovered in less than a fortnight without an untoward symptom. A case in which gastrotomy was successfully performed for the extraction of a silver fork was reported by Dr. Gayrooke, of Mondes, in 1820. Mr. Little, of London, lately succeeded in fishing out of the stomach a gold plate surmounted by four artificial teeth, one inch and three quarters in length by one inch and a quarter in width. The chief difficulty experienced was in getting the foreign body through the upper narrow portion of the œsophagus.

The astonishing faculty which the stomach possesses of accommodating itself to the presence of foreign bodies, is strikingly illustrated in the remarkable instances recorded by Borelli, Fournier, Harrison, and others, in which the most curious substances, as pieces of wood and iron, nails, forks, spoons, knives, buckles, compasses,

door-hinges, and pieces of coin, were swallowed, sometimes in large numbers, and in rapid succession, with very little immediate suffering, although they all ultimately proved fatal. A case is mentioned by Crollius of a man who lived many years in great comfort, after having swallowed forty-six pebbles, weighing altogether nearly three pounds, the smallest being about the size of a pigeon's egg. Dr. Otto, of Copenhagen, met with an instance in which a silver teaspoon, swallowed twelve months previously, was discharged through an ulcer in the precordial region, followed by recovery.

Gastrotomy was originally performed by Florian Mathis, of Brandenburg, in 1602, for the removal of a knife nine inches in length, swallowed by a man, thirty-six years of age, who made a successful and perfect recovery. Gruger, a Polish surgeon, repeated the operation in 1613, and Shoval in 1635, for a similar object, the patient of the former surviving ten years. After this gastrotomy seems to have been lost sight of until the latter part of the last century, when it was performed by Professor Frizac, of Toulouse, for the removal of a knife blade, two inches long. Since that period the operation has been practised four times, inclusive of the one above referred to by Dr. Bell; and, what is remarkable, every case made a rapid recovery. The mode of performing the operation is described at page 561.

The operation of *enterotomy* is sometimes required on account of the presence of a foreign body in the bowels, whether formed within, or introduced from without. In this country, intestinal concretions are exceedingly rare, but in certain parts of Europe, especially in Scotland, they are by no means uncommon, and occasionally call for the use of the knife. In the latter country, they usually consist of the fibres of the beard of the oat, cemented together by albumen and phosphate of lime, and sometimes acquire a very large bulk, weighing many ounces, and even three or four pounds. When small, they generally move about, changing their place from time to time; but, when the reverse is the case, they are liable to become impacted in a kind of pouch, formed by the expanded tube. In general, they are solitary, but now and then quite numerous, as many as several dozens being found in the same individual. Their increase is usually tardy. The symptoms denotive of their presence are colicky pains, a sense of weight and soreness at the site of the concretion, dyspeptic derangement, and mechanical obstruction to the evacuation of the feces, with gradual emaciation, and failure of the general health. When the foreign body occupies the rectum or sigmoid flexure of the colon, the patient is tormented with a constant desire to go to stool, tenesmus, and distress in the sacrolumbar region. When the concretion is large, or the emaciation considerable, it may generally be felt through the walls of the abdomen, and, if several are lodged together, they may even be made to strike against each other, so as to cause a distinct noise.

These concretions are sometimes ejected by vomiting or stool; when situated in the rectum, they may occasionally be extracted with the finger, scoop, or forceps. When they are not disposed of in this way, and life is in danger, enterotomy must be performed, the operation, not unfrequently, proving successful. An incision of adequate length being made through the abdomen, in the direction of the muscular fibres, at the site of the foreign body, the bowel is laid open to an extent barely sufficient to seize and extract it, when the opening is immediately closed with the continued or interrupted suture, as may be deemed most advisable. The external wound is treated in the ordinary manner.

Foreign bodies, introduced from without, give rise to the same train of symptoms as those formed within; but generally the effects are more violent, and the treatment requires to be more prompt and decisive. When the ordinary remedies have failed, recourse is had to the knife, the two wounds being managed afterwards in the same manner as in the former case. The operation is, unfortunately, not often successful, chiefly for the reason, perhaps, that it is commonly performed too late. In a case under Dr. Samuel White, of Hudson, early in the present century, a large teaspoon, swallowed in a paroxysm of delirium, was extracted in this way from the ileum, and the man recovered in a few weeks.

Dr. Thorndike, of East Boston, a few years ago, successfully removed, through an incision in the left iliac region, five inches in length, a stone, weighing nearly two pounds, that had escaped from the rectum into the peritoneal cavity, it having been introduced by the patient to promote the flow of urine. The report of the case states that hardly any inflammation was provoked either by the presence of the stone or by the performance of the operation.

SECT. VI.—INTESTINAL OBSTRUCTION.

Obstructions of the intestines may arise from various causes, some of them of the most opposite character, and a knowledge of this fact suggests the propriety of arranging them under the following heads: 1. Internal strangulation from the development of a membranous band, from the attachment of one portion of bowel to another or to an adjoining organ, or from unnatural adhesions of the free extremity of the vermiform appendage, omentum, ovary, or Fallopian tube. 2. Rotation of the tube upon its own axis, or around an axis formed by the mesentery. 3. Compression of one portion of bowel by another, by a tumor, an enlarged ovary, or a diseased uterus. 4. The interception of the intestine by an opening in the mesentery, omentum, or mesocolon. 5. Intussusception of the tube, or the falling of one portion into another. 6. Stricture, generally the result of carcinoma. 7. Concretions, foreign bodies, worms, or indurated fecal matter. 8. Paralysis. 9. Spasm. 10. Inflammation.

Of the relative frequency of these different species of intestinal obstruction, some idea may be formed when it is stated that of 169 cases, analyzed, in 1848, by Mr. Benjamin Phillips, of London, the impediment in 60 depended upon strangulation by bands of false membrane, in 69 upon intussusception, and in the remainder upon torsion and other causes, apart from imperforate anus and stricture of the rectum. The obstruction, however induced, presents itself under two distinct varieties of form, the acute and the chronic, each being characterized by a peculiar train of phenomena.

Acute obstruction is generally occasioned by internal strangulation by membranous bands, morbid adhesions, or some diverticulum; by a sudden twist of the bowel or by a rotation of the bowel upon its axis; by the passage of a coil of intestine into an abnormal aperture in the mesentery, omentum, or mesocolon; or by the occurrence of intussusception, or the falling of one portion of bowel into another, as in fig. 485, from a preparation in my collection. It may also arise from inflammation or spasm, although this is uncommon.

The symptoms which characterize this form of obstruction are generally of a most severe nature; they are more or less sudden in their appearance, and they bear the closest resemblance to those which denote the existence of strangulation in hernia. The individual may be in the most perfect health at the moment of their occurrence, or he may have been more or less unwell, although still able to attend to his accustomed business. The disease is usually ushered in by pain in a particular portion of the abdomen, of a sickening, griping, or colicky character, and soon followed by decided nausea, and a sense of constriction in the situation of the strangulation. Prostration is an early symptom. The vital powers are depressed, as if the system had received a violent shock. Excessive restlessness exists. The patient is in great agony; he tosses about in bed, his thirst is intense, and he is overwhelmed with despondency. The vomiting increases in frequency, and the ejected matter, consisting at first simply of ingesta, or of bile and mucus, at length becomes stercoraceous; the belly is exquisitely sensitive, so much so that the slightest pressure of the finger is almost intolerable; the bowels are tympanitic and obstinately constipated; the lower limbs are retracted to take off the weight of the abdominal muscles; the pulse is small, frequent, and wiry; the features are pinched; the extremities are cold; the mind wanders; in a word, the suffering is intense. By and by, muttering delirium sets in, the countenance exhibits the Hippocratic expression, the tongue is dry and black, the surface is covered with clammy perspiration, there is hiccup with twitching of the tendons, and, unless relief is speedily procured, the patient dies either from exhaustion or mortification of the bowel. The period at which this event occurs varies, on an average, from six to eight days.

Fig. 485.



Intussusception of the Bowel.

Sometimes it takes place as early as forty-eight hours from the commencement of the attack. Dissection generally reveals all the evidences of a high state of peritonitis.

In *chronic obstruction*, the obstacle to the onward passage of the feces usually depends upon organic disease of the bowel, as stricture of the rectum, sigmoid flexure of the colon, or ileo-cæcal valve; the presence of indurated feces, foreign matter, morbid growths, worms, or intestinal concretions; or, finally, upon the pressure produced by some tumor, as an enlarged ovary, uterus, or Fallopian tube.

The symptoms are much less violent than those which mark the acute attack. Their development is gradual, not sudden and overwhelming. The individual is unwell; his disease is slowly but steadily gravescent, worse at one time, and better at another. The chief trouble, at first, is constipation of the bowels, with rumbling noises and frequent eructations, disordered appetite, more or less torpor of the liver, and progressive failure of the strength. Colicky pains are occasionally experienced, and defecation is performed with great difficulty, being always accompanied with straining and tenesmus, and, at times, with prolapse of the rectum. Not unfrequently obstinate constipation exists. Sometimes the bowels are not relieved for days or even weeks, although the desire to do so may be most urgent. This is especially liable to be the case when the obstacle is seated in the rectum, from the pressure of the fecal matter upon the pelvic nerves. After the case has proceeded in this manner for a variable period, it gradually or suddenly assumes a more serious character, evidently dependent upon the occurrence of inflammation, which never fails to mark the close of the affection, whatever may be the nature of the exciting cause. The peritoneum is now the chief seat of the disease, and the danger is always in proportion to the extent and violence of the attack. In many cases the morbid action involves the entire membrane, visceral and parietal; in some it is more limited, being confined to the parts around the seat of the obstruction. The features are pinched and shrunk, the pulse small, frequent, and wiry, the abdomen tender and tympanitic, the stomach nauseated and unable to retain even the blandest fluid, and the surface covered with clammy perspiration. The strength rapidly fails, the mind wanders, hiccup and muscular twitchings ensue, and the patient sinks very much as one dying of mortification from strangulation of the intestines. In the worst cases stercoraceous vomiting is sometimes present.

Diagnosis.—The diagnosis of intestinal obstruction is often determined with difficulty. It is generally sufficiently easy when it depends upon disease of the rectum situated within reach of the finger or probe, or when it is occasioned by the presence of indurated fecal matter, an intestinal concretion, or some foreign body known to have been swallowed, but not passed by the anus. In almost all other cases it must necessarily be obscure.

The affection with which it is most liable to be confounded is hernia; for, whenever the case is one of sudden occurrence, the symptoms of the two diseases are absolutely identical. Error here is not always avoidable, even when the attendant is thoroughly upon his guard in respect to the probable nature of the case. The symptoms of hernia are sometimes extremely obscure. In the incomplete variety of the affection, there is often an entire absence of everything like a tumor, and the consequence is that the surgeon is left wholly to conjecture as to the precise character of the complaint. A very minute portion only of the wall of the bowel may be intercepted, and yet the transmission of fecal matter may be as effectually arrested as if the entire caliber of the tube were constricted. The symptoms of strangulation exist in full vigor, but no practitioner, however intelligent, can possibly affirm whether they are produced by a hernia, properly so called, or by mere internal obstruction. I have witnessed a number of such cases, and it need hardly be added that every one proved fatal.

In intussusception of the bowel, the access of the symptoms is generally sudden, and without any assignable cause. The individual is seized with violent pain in the abdomen, attended with nausea and vomiting, without any tension, tenderness, or appreciable tumor. The countenance is pallid, and he feels weak and depressed. Obstinate constipation exists, and the case effectually resists all attempts at relief, both by the mouth and the rectum. The suffering steadily progresses. The pain increases in violence; the abdomen is tympanitic and exquisitely sensitive; the pulse is small, hard, and frequent; the eyes are sunk; the anxiety is intense; and the vomiting is stercoraceous.

In obstruction dependent upon the pressure of a membranous band, a twist of the bowel upon its axis, or the passage of a coil of intestine through a hole in the mesentery, omentum, or mesocolon, the symptoms so closely resemble those of invagination and ordinary hernia as to defy all attempts at accuracy of discrimination. The most prominent phenomena are violent pain and tension of the abdomen, with great tenderness on pressure, excessive restlessness, fecal vomiting, pinched features, and a small, quick, thready pulse.

Obstruction caused by colic occasionally produces confusion in regard to the diagnosis of the case. In general, such attacks are dependent upon disorder of the digestive organs, or the presence of ingesta, bile, or acid in the alimentary canal. The pain is spasmodic, relaxing and increasing in severity with temporary intermissions; there are frequent eructations and rumbling noises in the bowels; the patient rolls about and seeks relief by compressing the abdomen; there is no fecal vomiting; and alvine evacuations occur either spontaneously or through the agency of medicine.

The passage of a gall-stone sometimes closely simulates the symptoms of intestinal obstruction, especially those dependent upon strangulation. The attack usually comes on within a few hours after a hearty meal, with severe pain, like that of colic, referred to the hypochondriac region, and paroxysmal in its recurrence, with intervals of comparative ease. The pain is generally extremely agonizing, but is always relieved by pressure. There is distressing nausea, with frequent vomiting of acid matter; the patient is excessively restless, rolling and tossing about in bed; the countenance is pale; the pulse is slow and weak; the tongue is foul; and the surface is covered with a cold sweat. If relief is not speedily afforded, the skin assumes a jaundiced aspect, the urine is tinged with bile, the abdomen is tender on pressure, especially in the epigastric region, and there are often well-marked rigors. When the concretion is very large, it may, upon escaping from the gall-bladder, obstruct the bowel, and thus occasion obstinate constipation, with all the symptoms of internal strangulation.

The most important phenomena, diagnostically considered, are, the spasmodic character of the pain, the icterode condition of the skin, the presence of bile in the urine, the soft and open state of the pulse, the absence of constipation and fecal vomiting, and the sudden cessation of suffering the moment the calculus escapes into the bowel.

Obstruction dependent upon mechanical causes, as morbid growths, concretions, foreign bodies, or indurated feces, may occasion much suffering, but in most cases the symptoms are for a long time comparatively mild, the bowel gradually accommodating itself to its new relations. Eventually, however, the case assumes a more serious character, and, if relief is not obtained, the patient perishes from peritonitis, preceded by excessive distention and tenderness of the abdomen, and great prostration of the vital powers.

The diagnosis of this kind of intestinal obstruction must often necessarily be very obscure. A stricture, carcinoma, hardened feces, or an intestinal concretion, occupying the lower part of the rectum, may generally be detected with the finger, probe, or bougie; but when the source of the difficulty is higher up, there can be no certainty as to its precise nature. When the impediment is very great, it may sometimes be detected through the walls of the abdomen, but such an occurrence must be very uncommon. Occasionally the obstacle is external to the tube, as when it is caused by an ovarian, uterine, or mesenteric tumor, and then the diagnosis is generally sufficiently evident.

Obstruction from mere torpor of the bowels is most common in nervous, hysterical females, and is usually readily recognized by the history of the case, the frequent eructations, and the rumbling noises in the abdomen. Obstinate constipation sometimes arises from injury of the spine.

The diagnosis of intestinal obstruction, the result of peritonitis, is marked by great uncertainty. The most reliable circumstances are, the tympanitic and tender state of the abdomen, the small, thready pulse, the coldness of the extremities, the frequent eructations, with occasional vomiting, or regurgitation of the contents of the stomach, dorsal decubitus, retraction of the limbs, absence of severe pain, shrunken features, general prostration, and obstinate constipation.

Much light is sometimes thrown upon the diagnosis of these affections by the history of the case, as the nature of the exciting cause, the peculiarity of the attack,

and the character of the symptoms. When the attack is sudden and violent, and speedily followed by peritoneal inflammation, the presumption is that it is dependent upon internal strangulation; while, if it is slow in its progress, or decidedly chronic, the probability is that it has been occasioned by mere torpor of the bowel, attended with fecal impaction, or by the presence of some morbid growth, carcinoma, stricture, intestinal concretions, worms, or foreign matter.

The pain in internal strangulation generally comes on suddenly, and, although it is liable to remit, it is nearly always continued. It usually begins at some particular spot, from which it is more or less rapidly diffused over the rest of the abdomen. In the more severe cases, it may be so intense as to cause death in less than forty-eight hours, the patient sinking as if he were laboring under violent shock. In the chronic form of the disease, on the contrary, there may be almost an entire absence of pain for days and even weeks together.

Along with pain, there is generally, in the more severe forms of the affection, considerable tenderness of the abdomen, either circumscribed or diffused. When the obstruction is rapid, it usually appears early in the attack, and is often so great as to render the slightest pressure of the finger intolerable.

Tympanites is a constant symptom, but of itself of little diagnostic value, as it is a concomitant of many other affections. It generally arises gradually, and often proceeds to a most distressing extent. When it exists in a very high degree, the abdomen is as tight as a drum, and the distended coils of intestine may readily be perceived through its stretched parietes.

The constipation is commonly complete. Sometimes, however, a small evacuation takes place, or a little fecal matter may be brought away by an enema. In the chronic form of the disease, the patient often labors under distressing tenesmus, with a frequent desire to relieve himself. A discharge of blood, or of offensive mucus, is a frequent attendant upon intussusception, especially if the disease has made some progress.

Vomiting is seldom absent. In acute obstruction, it commonly appears within a few hours after the attack, and continues, as a prominent and distressing symptom, until the case terminates. When the obstruction is chronic, it may not come on until late in the attack, or until there is serious peritoneal involvement. It is usually most harassing when the obstacle is seated in the small bowel, and when the patient is subjected to the use of irritating cathartics. It generally continues until the ejected matter acquires a fecal character.

Distressing hiccup often attends, especially when the impediment exists in the upper portion of the small bowel. It is, however, a symptom of no diagnostic significance.

The precise seat of the obstruction can only, as a general rule, be determined when the disease upon which it depends is situated in the rectum or lower part of the colon, within reach of the finger, probe, or tube. In most other cases, only an approximative opinion can be formed. When the constriction is in the small bowel, or at the ileo-cæcal valve, the swelling is usually central, and less considerable than when the large intestine is distended. When the inflation exists mainly in the colon, the tube not unfrequently forms a kind of belt around the boundaries of the abdomen, the outline of which may be distinctly traced through the stretched and attenuated parietes with the finger, if not also with the eye. An enormously distended cæcum is occasionally thrust over into the left hypochondriac region, where it presents itself as a large prominence, emitting a clear sound on percussion. In intussusception, a distinct tumor, more or less hard, and of an elongated, cylindrical form, may generally be traced; a circumstance which, coupled with the existence of bloody mucons discharge, is almost characteristic of the nature of the affection. Finally, in distention of the large bowel, there is always unusual fullness of the loins with remarkable resonance on percussion.

The symptoms are generally most urgent when the small bowel is involved; the pain and vomiting come on at a very early period, often, indeed, within the first few hours, and the attack is characterized by uncommon severity; the abdominal tenderness is greater, the pulse smaller, and the prostration more rapid and profound.

The impossibility of inserting a long tube into the bowel may generally be taken as an evidence that the obstruction is seated in the upper part of the rectum or in the sigmoid flexure of the colon; but it must not be forgotten, in the use of this instrument, that it may bend upon itself, and so convey erroneous information. When the

impediment is situated low down in the rectum, its character may always be readily ascertained with the finger, probe, or bougie.

Finally, it should be borne in mind that carcinomatous obstruction is most common in the sigmoid flexure of the colon, and in intussusception in the left portion of the large intestine, the displaced tube often lying in the rectum, and sometimes even protruding at the anus. Moreover, whenever the case is of an acute character, simulating strangulation, a most thorough examination should be made of the abdomen, especially in the situation of the inguinal, femoral, and pelvic apertures, for some of the more obscure forms of hernia; for it has often happened that the obstacle, instead of being internal, has been found after death to be external, a small portion of bowel having been intercepted by the edges of one of the rings.

Great uncertainty in regard to the diagnosis often arises when intestinal obstruction occurs in a person laboring under chronic hernia. The obscurity, in such an event, can only be cleared up by a most careful exploration of the parts concerned in the protrusion. If the hernia is reducible, the finger should be carried into the abdominal ring, and if, after this, doubt still exists as to the real nature of the case, the proper plan is to operate.

Treatment.—In the absence of correct diagnostic intelligence, the treatment of intestinal obstruction must often be conducted in a purely empirical manner. One important fact, however, in regard to the subject is now fully settled, the avoidance of everything in the form of irritating medicine, until recently so much employed even by the best practitioners. If a drastic cathartic, as colocynth, scammony, jalap, or croton oil, has occasionally afforded relief, it is very certain that the tendency of such an agent generally is to do harm, by increasing the gastric distress and promoting abortive peristaltic action of the bowels. The same objection is applicable to the exhibition of crude mercury, which, instead of unlocking the intestine, only, in most cases, augments the mechanical impediment. Numerous instances have been published in which enormous quantities of this metal were found, after death, in the bowel without, apparently, having made the slightest impression upon the obstruction.

In the milder cases success will often attend our treatment, and even in the more severe ones the surgeon need not always despair of being able to surmount the difficulty. In intussusception, nature occasionally affords relief by the occurrence of mortification, eventuating in the separation and discharge of the invaginated portion of the tube. The late Professor Dawson, of Columbus, Ohio, presented me a portion of colon twenty-nine inches in length, passed by a child six years of age, who, notwithstanding, made an excellent recovery. Dr. Van Buren and Dr. Peaslee have each reported favorable instances of five feet. In 35 cases, analyzed by Dr. William Thomson, the invaginated pieces varied in length from six inches to three feet, nearly all including the entire cylinder of the tube along with a portion of the mesentery. The small bowel was concerned in 22 cases, and the large, or large and small, in 13. The average duration of the disease was from four to five weeks. To insure so favorable a result, it is evident that everything should be done to sustain the system, and that all perturbing measures should be carefully refrained from, especially during the elimination of the slough, otherwise they may break up the adhesions.

The great remedy in nearly all cases, whether dependent upon strangulation, or constipation, is opium, administered in liberal and sustained doses. The object is not merely to allay pain and gastric irritability, but, for a time at least, to prevent the peristaltic action of the bowels. In this way, especially in intussusception, an opportunity is afforded to the affected intestine either to unroll itself or to throw off the invaginated portion, whereas, if the tube has been twisted upon its axis, or strangulated by bands of lymph, a diverticulum, morbid adhesions, or a hole in the mesentery, the patient will be made comparatively comfortable, and thus placed in a better condition to bear up under surgical interference, should this eventually become necessary. When the difficulty depends solely upon torpor of the bowels, experience has shown that the steady, persistent use of opium will, in time, more effectually relax them than any other remedy; and the same treatment is strictly applicable when the obstacle is occasioned by spasm. The quantity of opium should not be less than two grains, given every six or eight hours, according to the urgency of the case. When there is marked disorder of the secretions, a minute quantity of calomel, as one-half a grain to a grain, may often be advantageously combined with the

anodyne, but anything like a large dose of the article would be decidedly prejudicial, from its tendency to excite nausea, to provoke peristaltic action, and to depress the system. When great torpor of the bowel exists, strychnia may be serviceable. Gastric distress may generally be relieved by effervescing draughts, the neutral mixture, champagne, or lime-water in milk.

Abdominal tenderness should be assuaged with leeches, and fomentations, medicated with laudanum. A light emollient cataplasm, similarly prepared, sometimes answers a good purpose. When the distress is very great, the best plan is to cover the abdomen with a large blister, well sprinkled with morphia.

Great relief has sometimes followed exposure of the abdomen to cold air. From facts lately developed, it is highly probable that intussusception may occasionally be cured in this manner, the bowel releasing itself by reversed peristaltic action. Ice-water, or pounded ice applied to the abdomen, might be useful. The strength is maintained with nutritious food, given in as concentrated a form as possible. Milk punch is generally required at an early period of the attack.

To remove the flatus, which is always a source of so much distress, nothing answers so well as frequent injections of turpentine largely diluted with tepid water, and introduced with a long tube, inserted high up into the colon. In obstinate cases trial should always be made with injections of cold water. In intussusception great relief has occasionally followed the inflation of the intestines with air introduced by means of a tube attached to a bellows. When the displaced bowel projects through the anus, or is low down in the rectum, reduction may be attempted with the fingers, a bougie, or even, if the patient is an adult, with the hand. Tenesmus is relieved with anodyne enemas, or enemas of olive oil, mucilage of gum arabic, or infusion of flaxseed.

My opinion has long been that great, if not permanent, relief might be afforded in some of these cases of excessive gaseous distention by puncture of the bowel, as the escape of the fluid might not only enable the tube to regain its contractility, but facilitate respiration by taking the pressure off the diaphragm and abdominal muscles. No opportunity, however, was presented to me of putting this idea into practice until 1864. The patient was a man, fifty-one years of age, under the charge of Dr. Andrew Nebinger. He had already had one attack of obstinate constipation, attended with great pain in the bowel, of a paroxysmal character, rumbling noises, and excessive distention. After continuing in this condition, alternately better and worse, for twenty-one days, copious alvine evacuations occurred, and the health improved so much that he was able to walk about his room. At the end of three weeks, however, the symptoms returned in all their previous intensity. The pain and meteorism steadily increased, the stomach was oppressed with nausea, and all efforts to move the bowels with purgatives, enemas, and a long rubber-tube proved fruitless. When I saw the patient, the tympanites was so excessive that he was hardly able to breathe or swallow. As a dernier resort, I introduced a very delicate trocar at the middle line, first about two inches below, and then about the same distance above, the umbilicus. A large quantity of gas, of a fecal odor, escaped at each orifice, followed by great relief of the suffering and the most marked reduction of the size of the abdomen. The improvement continued for nearly a fortnight, when the man became gradually worse, and died exhausted in less than a week, no alvine evacuation having occurred during the entire period of thirty-five days.

The cause of the obstruction was found to be a tight scirrhus ring at the lower part of the sigmoid flexure of the colon, completely occluding the tube. The whole of the large bowel was enormously distended with gas and fecal matter, especially the latter, more or less displaced, and upwards of twelve inches in circumference. A gangrenous perforation existed in the descending colon, and the mucous membrane was ulcerated at two points. The peritoneum of the lower portion of the abdomen was highly inflamed, and there was some effusion of serum and lymph.

Although this case necessarily terminated fatally, it is evident that the operation afforded great relief, and I can see no reason why it should not be frequently practised, on the principle, if nothing more, that anything calculated to ameliorate suffering is proper under such desperate circumstances. In Bolivia, where gastrointestinal pneumatosis is very common, especially among the natives who live almost exclusively upon vegetables, puncture of the stomach has been repeatedly performed with very gratifying results. Of 20 cases operated upon by Dr. Olivieri 8 were perfectly successful. In a discussion of this subject in the Academy of Medicine of

Paris, in July, 1871, the important fact was elicited that this operation had been successfully performed by many of the French surgeons, as Bouley, Depaul, Nélaton, Guérin, Piorry, Barth, Blot, Giralès, and Fonssagréves. It has also been successfully performed by Stein, Oppolzer, Hochstetter, and other German surgeons. Ordinarily one or two punctures suffice, but when the bowel is loaded with fecal matter, and divided, as it were, into different compartments, a greater number may be required. The most suitable instrument for performing the operation is a very delicate trocar.

Excessive distention of the abdominal cavity may arise from the extrication of gas in peritonitis. In such an event the bowels will be pushed back by the accumulated fluid, beyond the reach of the finger, and a hollow, drum-like sound emitted on percussion. The respiration is generally embarrassed, and, in some instances, the dyspnoea is so excessive as to threaten asphyxia.

As to the propriety of enterotomy, in such cases, the question presents great difficulties. Of these the most important are the uncertainty of the nature of the disease, and the fact that the division of the peritoneum is always attended with extreme risk to life, especially when it is severely congested, if not actually inflamed. An operation may be performed for one of two objects, either to relieve internal strangulation, or to establish an artificial anus, as when the obstruction depends upon the existence of carcinoma of the colon. In the former case, the peritoneum must necessarily be cut; in the latter, on the contrary, it may readily be avoided by making the opening in the lumbar region. In two instances in which, after mature consultation with eminent physicians, interference was deemed advisable, I signally failed in conferring the slightest benefit by these procedures, one patient dying at the end of four hours, the other in less than thirty-six. I have myself no fancy for this kind of interference. In internal strangulation, depending upon intussusception, a twist, or the interception of the bowel by an aperture in the omentum, the diagnosis is so uncertain that the proper time for relief is usually allowed to pass before an operation is agreed upon, and when, at length, it is performed, the case must, almost of necessity, speedily terminate fatally.

SECT. VII.—ARTIFICIAL ANUS.

The establishment of an artificial anus is indicated when life is placed in imminent jeopardy on account of the existence of some insurmountable mechanical obstacle to the evacuation of the feces. Hence, in cases of obstruction from carcinomatous stricture of the rectum, the sigmoid flexure, or the transverse colon, and of obstruction from non-malignant stricture, adhesions, or the pressure of morbid growths, the operation is generally considered not only as justifiable, but as imperatively called for as a means of prolonging life. As a choice of evils, lumbar colotomy may also be employed for the relief of vesico-intestinal fistules, and to mitigate the exquisite suffering produced by the passage of the feces in cases of ulcerated rectum, without there being actual obstruction. But, although this may be so, I cannot, I must confess, appreciate the benevolence which prompts a surgeon to form an artificial outlet for the discharge of the feces in a case of imperforate anus in a child, in whom the rectum is either completely absent, or terminates blindly several inches above its normal situation. Let the surgeon, if he be a parent, ask himself the question, whether he would not rather see his child die without an attempt at relief than to place it in a condition that would only render it an object of disgust to itself, and of loathing to every one around.

Littre, as early as 1710, proposed, in a case of imperforate anus, to reach the bowel by an incision through the left lumbar region, the design being to open the sigmoid flexure of the colon, and then to secure the orifice in the tube to the wound in the walls of the abdomen by means of a thread passed through the mesentery. The first attempt, however, to carry out this suggestion, or, more correctly speaking, the principle upon which it was founded, was made by Pillore, of Rouen, in 1776, in the case of a man affected with a carcinomatous tumor of the rectum, completely obstructing the evacuation of the feces. The artificial anus was made in the cæcum, and the patient survived twenty-eight days, the immediate cause of death being violent inflammation of the jejunum, occasioned by the accumulation of an immense quantity of metallic mercury, taken previously to the operation. The first operation of this kind that was ever performed for the relief of imperforation of the anus was

executed by Dubois, in 1783; but it was unsuccessful, the child dying on the tenth day. Duret, of Brest, in 1793, was more fortunate. He opened the sigmoid flexure of the colon of a child two days old, who not only survived the immediate effects of the operation, but, when last heard from, had attained the age of forty-two years. Four years after this, Fine, of Geneva, made an artificial anus in the arch of the colon, by cutting through the umbilical region of a woman, aged sixty-three, in a case of constipation from scirrhus of the upper part of the rectum. She lived upwards of three months and a half, when she perished from the effects of the disease.

Two distinct processes have been employed for establishing an artificial anus; in one, usually known as that of Littre, the bowel is entered through the peritoneum, both parietal and visceral; and in the other on the outside of that membrane, in the space left uncovered by the fold of the mesocolon. The latter was originally described by Callisen, of Copenhagen, in

1796, in his *System of Surgery*, but whether the suggestion was his own or not is not known. However this may be, the operation was almost universally condemned by the profession, on account of its supposed difficulties, until 1835, when it was revived and improved by Amussat, of Paris.

The operation of Amussat, fig. 486, the only one which I shall formally describe, consists in perforating the bowel through the iliac fossa, midway between the last rib and the crest of the ilium, the incision commencing at the edge of the sacrolumbar and long dorsal muscles, and extending horizontally forward for about four inches. The skin and subcutaneous cellular tissue having been divided, the muscles and aponeuroses are successively penetrated to the full extent of the external wound, constant use being made of the grooved director, especially as we approach the more deep-seated structures. In very corpulent subjects, it is sometimes necessary, in order to obtain a sufficiency of room, to incise the different muscular layers perpendicularly, so as to give the wound somewhat of a



Amussat's Operation for the Formation of an Artificial Anus in the Lumbar Region.

crucial shape, but, in general, this may be obviated by drawing the parts forcibly asunder with stout retractors. The muscles involved in the operation are the broad dorsal, external oblique, internal oblique, and transverse abdominal, together with a small portion of the square lumbar, although this occasionally entirely escapes. The bottom of the wound is formed by a large quantity of cellulo-adipose substance, especially conspicuous in fat subjects; this must next be carefully divided with the finger, or handle of the scalpel, and the colon sought for as it lies in the iliac fossa, at a point almost midway between the anterior and posterior spinous processes of the ilium, but a little nearer to the latter than the former. The colon is generally easily recognized by its greenish hue, by its fixedness, and by its distended condition, the latter causing the small intestine to be pushed out of the way. As soon as the cellular connections at the bottom of the wound have been severed, the bowel will project freely forward, and is then to be pierced with a tenaculum, in order to prevent it from slipping back after it has been incised. A transverse opening is now to be made into the most prominent portion of the gut, about two inches in length, and its edges tacked to those in the external wound by at least six sutures, two corresponding with each side, and one with each angle. The whole procedure of incising and stitching the bowel should be conducted with the greatest possible care, lest fecal extravasation occur, and so produce severe inflammation. Despite this precaution, however, a portion of the contents of the tube generally escapes as soon as penetration has been effected. Thorough clearance having been established, the patient is replaced in bed, and the parts are covered with tepid water-dressing.

Very little bleeding usually attends the operation, as, owing to the horizontal direction of the incision, only a few vessels are divided. In the operation of Callisen, in which the incision is perpendicular, the hemorrhage, on the contrary, is frequently considerable.

The operation of Amussat may be performed upon either side; in carcinoma of the rectum, or recto-anal region, however, it is always best to select the descending colon. The procedure is usually difficult of execution, especially in infants and children, and, unless conducted with great care and judgment, is very liable to be followed by injury of the peritoneum.

Any tendency to undue contraction of the artificial anus should be counteracted by means of tents; and pains should be taken, as soon as the parts have sufficiently recovered from the effects of the operation, to furnish the patient with a suitable apparatus for preventing the escape of fecal matter. In some cases, there is a strong disposition to protrusion and eversion of the mucous membrane of the bowel, but this generally soon disappears of its own accord. The greatest attention must constantly be paid to cleanliness.

Dr. S. W. Gross has analyzed 67 cases, including 44 tabulated by Mr. Cæsar Hawkins, in which an artificial anus was established by Amussat's operation for the relief of non-congenital obstruction and of vesico-intestinal fistule. Of these 24 died within the first five weeks, and 43, or 64 per cent., survived the operation, 39 being examples of carcinomatous stricture or obstruction, of which 16 perished and 23 recovered, the latter being in the ratio of 58.97 per cent. One patient was alive at the expiration of twenty-seven months; a second survived two years; while the average duration of life was nine months. For non-malignant obstruction and ulceration the operation was practised 25 times, with 7 deaths and 18 recoveries, the latter being in the ratio of 71.42 per cent. One patient was living and comfortable at the end of fourteen years; two enjoyed good health at the expiration of three years, and one after an interval of four years; while the average duration of life was thirty-one months. Of 3 cases operated upon for vesico-intestinal fistule, 1 died on the eighteenth day, but 2 were still alive and in good health at intervals of five and eight months.

The results of Littre's operation have been carefully brought together by Mr. Hawkins, in an able paper in the thirty-fifth volume of the Transactions of the Medico-Chirurgical Society of London. The number of cases analyzed was 12, of which 7 perished within the first five weeks, and 5, or 41 per cent., survived the operation. Of 4 examples of carcinomatous obstruction, 2 died and 2 recovered, both patients surviving for twelve months. Of 8 operations for non-malignant stricture 5 died and 3 recovered. Of the former 3 were fatal from peritonitis, while of the latter one was alive at the end of six months, one at eighteen months, and one was living after an interval of seventeen years.

From the facts furnished by Dr. Gross it is obvious that lumbar colotomy is decidedly preferable to the direct abdominal incision, since the recoveries are in favor of the former by 23 per cent. In only two of the fatal cases was there any evidence of recent peritonitis, and in only one of these was this affection assigned as the cause of death. Recent peritonitis was present, on the other hand, in four of the seven fatal cases by Littre's method, and death was ascribed to it in three. The success of the procedure, as might naturally be expected, is materially influenced by the nature of the disease for which it is practised, the mortality after carcinomatous affections being greater by 13 per cent. than after non-malignant disease.

SECT. VIII.—AFFECTIONS OF THE OMENTUM AND MESENTERY.

The only affections of the omentum and mesentery, of any surgical interest, are wounds, hypertrophy, hydatids, serous cysts, colloid, encephaloid, and scrofulous tumors.

Wounds of the omentum are treated upon the same principles as similar injuries of the other contents of the abdomen. If the parts protrude at the external opening, they may, if seriously lacerated, require to be retrenched, care being taken to ligate any vessels that may, if left to themselves, be likely to bleed. A laceration of the omentum, unaccompanied by any outward marks of injury, sometimes causes death, as in a case reported by Dr. Derner, of a hussar, who, in a violent leap of his horse, received a rent in this membrane, one inch and a half in length, from the effects of

which he died the next morning. The dissection revealed the existence of five ounces of blood in the peritoneal cavity.

Hypertrophy is most common in old, capacious hernias attended with protrusion and long retention of the omentum, which is then entirely changed in its character, deprived of its serous structure, and composed of a hard, dense mass, rough and tuberculated on the surface, as if it were inlaid with fibro-cartilaginous matter. Similar alterations occasionally arise from chronic disease when the omentum retains its intra-abdominal relations, the membrane being rolled up into a firm, solid mass, having more or less of the shape and consistence of a fibroid tumor, perhaps the size of a fist or even of a foetal head. Such formations not unfrequently contain serous cysts, colloid substances, or fibro-cartilaginous concretions, either alone, or variously combined; and, consequently, may, especially if they are of considerable bulk, literally fill the abdominal cavity, thus simulating an enlarged ovary, a fibroid tumor of the uterus, a hypertrophied spleen, or some heterologous growth, as colloid or encephaloid. A good illustration of such a mass is represented in the annexed sketch, fig. 487.

Hydatids of the omentum, or of the omentum and mesentery, seldom occur except as secondary formations in connection with hydatids of the liver and spleen. Vary-

Fig. 487.



Hypertrophied Omentum.

ing in size between a marble and an apple, they are of a spherical shape, solitary or multiple, and inclosed each in a distinct sac, in which the acephalocyst with its echinococci securely resides. When the hydatids are very numerous or fully developed, a large tumor may thus be formed, very much as in the case of a hypertrophied omentum, and liable, like it, to lead to errors of diagnosis.

Serous cysts of the omentum and mesentery are uncommon. Such formations are more liable to arise beneath the peritoneum in the wall of the abdomen, where they sometimes acquire a very large bulk.

A colloid tumor not unfrequently forms in the omentum, and may eventually acquire an enormous size, as in several cases that have been under my personal observation. The disease is usually tardy in its development, and, in its progress, nearly always involves the abdominal and pelvic viscera, the morbid growth sending processes about in different directions, so as to encroach more or less upon the functions of the contained organs.

The encephaloid tumor of the omentum is uncommon. Its growth is generally rapid, and it sometimes attains an extraordinary volume. Thus, in a specimen in my private collection, kindly sent to me by Dr. George E. Conant, of Ohio, the mass weighed upwards of eleven pounds, and occupied the whole abdominal cavity, covering in the urinary bladder, uterus, bowels, spleen, and liver, and reaching as high up as the ensiform cartilage of the sternum. The patient, a child, five years of age, suffered from the most frightful dyspnoea, and died in a state of great emaciation.

Great enlargement of the mesenteric glands sometimes arises, generally in young children, the subjects of strumous disease in various parts of the body. When a considerable number of these structures are affected, a tumor the size of a big fist, or even of a foetal head, may thus be formed, of a globular shape, of a dense, firm consistence, and more or less movable, although eventually it becomes firmly fixed in its position.

The diagnosis of these different formations must be based, in great degree, upon the rapidity of their development, the shape, volume, and mobility of the particular growth, and the condition of the general health. A roughened and enlarged omentum may often be distinguished by its superficial situation, its hard feel, and its tuberculated outline. When it is converted into a sarcomatous mass, it usually presents itself as a firm, circumscribed tumor, rolling about under the fingers, and changing its position with the movements of the patient.

The existence of hydatids of the omentum and mesentery may be suspected when, along with marked disease of the liver, or liver and spleen, there is enlargement of

these parts with a faint sense of fluctuation and crepitation. When the tumor is adherent or immovably fixed, an exploring needle may be used, the fluid, if any follow its withdrawal, being subjected to microscopic inspection with a view to the detection of echinococci.

Serous cysts may generally be detected by their soft, semielastic, fluctuating feel, the history of the case, and the aid of the exploring needle.

Solid tumors of these structures cannot always be readily distinguished from each other. The colloid is characterized by its great hardness, the uniformity of its surface, its superficial situation, and its tardy development. The symptoms of the encephaloid growth are, in most respects, diametrically opposite to those of colloid. Rapid development, inequality of surface and consistence, and rapid impairment of the general health are its most important features. Encephaloid occurs at all periods of life; colloid chiefly in middle-aged and elderly persons.

Mesenteric tumors are distinguished by their excessive hardness, the irregularity of their surface, and their deep and median situation. They generally occur at an early period of life, and nearly always coexist with evidence of strumous disease in other parts of the body.

The examination of these various formations will be greatly facilitated by an empty state of the bowels and bladder, thorough relaxation of the abdominal muscles, and change of posture, the patient being turned from side to side, upon his back, and even upon his face. The distinction between these growths and an aneurism of the abdominal aorta and of its larger branches is always readily determined by the absence of pulsation in the former and its presence in the latter.

The surgery of omental and mesenteric tumors is in its infancy. Whether it will ever be sufficiently daring to invade a region so fraught with danger the future alone can determine. Omental tumors might, no doubt, occasionally be removed with safety, especially when they are of a sarcomatous, cystic, or hydatid character. The malignant, on the contrary, should under no circumstances be interfered with.

SECT. IX.—INJURIES AND DISEASES OF THE LIVER

Wounds.—Wounds of the liver are infrequent in civil practice, but common enough in military. Varying in their nature, site, and extent, they are generally attended with considerable hemorrhage, and are always to be regarded as serious accidents. The symptoms are often extremely obscure. The most reliable, perhaps, in a diagnostic sense, are, a fixed pain and a feeling of weight in the region of the affected organ, and a discharge from the wound of bilious matter, of a yellowish or greenish color, very thin, and of a viscid consistence. Along with these symptoms there is generally gastric irritability, with frequent vomiting, great thirst, constant jactitation, and excessive prostration, occasionally amounting to complete collapse. If the patient survives a short time, the eyes, skin, and urine become jaundiced, and there is violent headache, with indescribable languor. Sometimes the nature of the accident is revealed by an escape of hepatic tissue at the wound. In most cases important information may be obtained, in regard to the probable character of the injury, by observing the situation and direction of the external opening, or the course pursued by the vulnerating body. When two orifices exist in the hepatic region, at opposite points of the body, and there is at the same time a discharge of bilious matter, there can hardly be any doubt respecting the diagnosis. In wounds of the gall-bladder there is commonly a flow of pure bile.

It is easy to understand why wounds of the liver are so frequently attended with severe hemorrhage. The organ is extremely vascular, having three distinct sets of vessels; and hence it is impossible for any weapon, however small, to penetrate the parenchymatous substance without dividing some of their branches. If the wound involves a large vascular trunk, the hemorrhage may prove fatal, either speedily or soon after its infliction, as in the case of a man, twenty-eight years of age, who, in an affray, received a transverse cut in the epigastric region, three inches in length, penetrating the peritoneal cavity, along with the left lobe of the liver, which projected at the external opening. He lived thirty-six hours, looking very pallid, and having a small, feeble pulse. He bled considerably at the wound. On dissection, performed by Dr. Gilpin, the medical attendant, the cut in the liver was found to be an inch and a half in length by three-quarters of an inch in depth; the parts around were incrustated with coagula, and nearly three quarts of fluid blood were contained

in the abdominal cavity. There was hardly any trace of peritonitis. A little wound, not three lines in length, existed in the omentum. The man had evidently died from loss of blood, chiefly of the liver.

Wounds of the liver, especially gunshot, are among the most fatal of accidents, death, if not instantaneous, generally coming on within the first forty-eight hours after the receipt of the injury, in consequence of the joint agency of shock, hemorrhage, and peritonitis. Of 32 cases reported by Dr. Otis, in circular No. 6, only 4 recovered. Hennen has recorded 2, and Guthrie 5, examples of recovery from gunshot wounds of the liver. The subjoined case affords an additional proof that such lesions are not always fatal.

A boy, eight years of age, was accidentally shot with a pistol, the ball entering on the right side, between the eleventh and twelfth ribs, nearly midway between the linea alba and the spine, and emerging on the opposite side of the spine, not quite half an inch from the median groove, both openings being situated on the same horizontal plane. Considerable hemorrhage followed, which, together with the shock of the injury, produced an alarming degree of prostration, amounting to absolute collapse, and lasting upwards of two days. Under the influence, however, of injections of brandy and hartshorn, with sinapisms to the extremities, chest, and spine, the boy soon began to revive, and at the end of twenty-four hours the reaction seemed to be complete. Free suppuration gradually arose, attended by the discharge of a slightly greenish, viscid fluid, having every appearance of bilious matter. This continued for about ten days, when it progressively diminished, both wounds closing in less than a month. The treatment, after the establishment of reaction, consisted simply of an occasional laxative, and of light, but nutritious, food, with a liberal use of brandy. The recovery was complete. Six years after the accident, the anterior scar was four inches below the axilla, as the arm hung by the side, and six inches from the posterior one.

Wounds of this organ, inflicted with the sword, sabre, or bayonet, occasionally get well. Dr. N. R. Smith has recorded an instance of recovery from a stab in the liver with a table-knife; a similar case, only much more severe, occurred to Dr. Roux, of St. Petersburg; and in one reported to me by Dr. T. A. Andrews, of this city, although the wound in the liver was fully two inches in depth, and of nearly that length, the patient, a man, twenty-two years of age, was perfectly well at the end of four weeks.

A remarkable case of incised wound of the liver, four inches in length by one inch in depth at the deepest part, inflicted by a circular saw, attended with the complete division of the eighth, ninth, tenth, and eleventh ribs, the costal pleura, and the diaphragm, and followed by rapid recovery, in a lad, fifteen years of age, was reported, in 1869, by Mr. Hamnet Hill, of Ottawa City. The large external wound, closed with fourteen sutures, united, in great degree, by the first intention. The internal treatment consisted mainly of supporting measures, with the free use of opium.

The liver is sometimes severely lacerated by falls, blows, or kicks upon the side, or by the forcible compression of the body, as when it is jammed in between two hard, resisting objects, as a post and the wheel of a carriage. Such accidents are not always attended by external marks, not even by any contusion of the skin. The number, extent, situation, and direction of the fissures vary much in different instances. More or less hemorrhage necessarily attends such accidents, especially when there is extensive rupture of the peritoneal coat of the liver. Occasionally this membrane retains its integrity even in severe laceration of the hepatic substance, and then the effusion of blood is slight.

The following case will serve as an example of such an accident: A stout, athletic boatman, twenty-three years of age, in a fit of delirium, jumped off the portico of a house upon the pavement below, a distance of fifteen feet, bruising and otherwise injuring several parts of his body. Death occurred in an hour after the accident. The liver, somewhat enlarged, softened, and of a dark bluish color, was lacerated in thirteen places. The rents ran in different directions, and, with the exception of two, were perfectly distinct from each other. They varied in length from a few lines to four inches, and in depth from two and a half to six lines, none extending completely through the substance of the organ. The spleen was ruptured on its convex surface, the right kidney ecchymosed, and the small intestine extensively contused. The abdominal cavity contained upwards of eight pounds of fluid blood. None of the large vessels were injured.

In the treatment of these wounds of this organ, the great object is to limit inflammation, by the most perfect quietude, gentle enemas, and a careful restriction of the diet. If the patient be young and robust, the use of the lancet may be required; otherwise it will be better to be contented with leeches, fomentations, and blisters. When suppuration is threatened, mercury, to the extent of slight ptyalism, is administered, to modify the inflammatory action and favor resolution. Pain is relieved by the liberal use of anodynes.

When a portion of the liver protrudes at the wound, it should be promptly restored to its natural position, the opening, if necessary, being dilated for the purpose. If some time have elapsed since the occurrence of the accident, it might be proper to let it remain, inasmuch as its reduction might, in such an event, occasion fatal peritonitis. Instances have been related by Blankaard, Schmucker, Dieffenbach, Macpherson, and others, in which the projecting piece was either cut off or removed by ligature, and yet a good recovery ensued.

Hydatid Tumors.—Hydatids, forming tumors of variable size and shape, and almost uniformly inhabited by echinococci, are occasionally met with in the liver, most generally upon its convex surface and at its inferior border, either alone or in union with similar products in other parts of the body. Usually arising without any assignable cause, their development is sometimes traceable to external injury, as a blow or fall upon the side; and, although they may occur at any period of life, they are most common from the age of thirty to that of fifty. In their shape, they are generally globular, but, when several are clustered together, they are more or less compressed and flattened; they are occupied, while young and healthy, by a thin, saline, non-albuminous, colorless fluid, and are contained each in a dense, fibrous cyst, of a white, opaque appearance. In old cases, however, or when suppuration has taken place, the fluid is generally turbid, and tinged more or less with bile. Occasionally the tumor is filled with a substance resembling putty, plaster, or cheese, intermixed with fragments of dead hydatids.

Ordinarily of tardy growth, these hydatids manifest, in time, a disposition to perish, either in consequence of inflammation set up in their own structure, or as an effect of disease in the neighboring hepatic tissues, followed either by the death of the patient, or by a process of elimination by which they find their way into the bowel, gall-bladder, lung, or peritoneal cavity. In rare cases, they escape through the walls of the abdomen. A liver, affected with hydatids, may be of the normal size and shape, although generally it is variously altered in these respects.

The *diagnosis* of hydatids of the liver must necessarily be very difficult, if not impossible, in the earlier stages of their existence. As soon, however, as they have attained a considerable bulk, they are commonly sufficiently easy of detection. A sense of weight and of uneasiness is generally felt, but severe pain exists only when the tumors are of rapid formation, inflamed, or so large as to interfere seriously with the functions of the organ. Up to this time also there is ordinarily no disturbance of the general health. The most important signs, diagnostically speaking, are the tardy but steady development of the growth, its globular shape, its comparative indolence, and its fluctuating character. As it increases, it gradually encroaches upon the walls of the abdomen, lifting them up, and thus causing a distinct projection, readily perceptible by sight and touch. During inspiration, the hydatidic fremitus, as it is termed, is sometimes noticed. When the tumor is of great bulk, there is generally extraordinary enlargement of the superficial veins of the abdomen. The affections with which it is most liable to be confounded are, abscess of the liver, carcinoma, enlargement of the gall-bladder, and aneurism of the aorta.

Abscess of the liver is comparatively rapid in its formation, and is invariably accompanied by well-marked symptoms of hepatitis, followed by rigors and severe pulsatile pain. Hydatids, on the contrary, are of tardy development, indolent, and unattended by inflammation, except when they are very old, or in a state of decay.

In *carcinoma*, the tumors are multiple, forming small, hard, circumscribed projections on the surface of the organ. They are always accompanied by severe pain, of a sharp, lancinating character, and by more or less jaundice, followed, as the disease progresses, by unmistakable signs of the cancerous cachexia. Encephaloid has sometimes a soft, elastic feel, and may even afford obscure fluctuation.

In dilatation of the *gall-bladder*, there is invariably deep jaundice, which is rarely, if ever, present in hydatids, except in their more advanced stages. The affection, generally caused by mechanical obstruction, is marked by the existence of a smooth,

globular tumor, free from pain and tenderness, characterized by a distinct sense of fluctuation, and situated at the lower border of the liver, the movements of which it readily obeys. The alvine evacuations always show an absence of bile.

From *aneurism* of the aorta, hydatids of the liver are distinguished by the absence of pain, pulsation, and bellows-murmur; by the more gradual development of the tumor; and by the freedom from sympathetic disturbance, always so prominent in aneurism. When the tumor is not arterial, but derives its pulsation from its proximity with the aorta, the nature of the case may, in general, be easily determined by placing the patient upon his knees and elbows, to favor gravitation.

When the walls of the abdomen are very thin, valuable information may be derived from the use of the exploring needle. If the fluid is clear and colorless, perfectly uncoagulable, strongly saline to the taste, and of the specific gravity of 1010, the probability is that it is from an *acephalocyst*, as no other fluid of the body possesses such properties. When the tumor discharges itself externally, into the bowel, or through the lung, the fluid may contain characteristic hooklets, discoverable by the microscope.

When a hydatid tumor of the liver, after having been long indolent, inflames and suppurates, the occurrence will be denoted by severe pain and tenderness in the right hypochondriac region, followed by rigors, and excessive constitutional disturbance. The matter thus formed may discharge itself in different directions, as in an ordinary hepatic abscess, as the peritoneal or thoracic cavity, stomach, bowel, bile-duct, or wall of the abdomen. A hydatid tumor, especially if very large, may cause serious mischief by its pressure upon adjacent structures. A not uncommon effect is ascites. The duration of the disease varies, on an average, from two to four years. In certain cases, the tumor occasionally retains its vitality for fifteen, twenty, and even thirty years, as in some of the examples analyzed by Barrier.

In the *treatment* of hydatid tumors of the liver nothing whatever is to be hoped for from internal medication. Indeed, the only reliance is upon puncture of the sac with a very delicate trocar, introduced in such a manner as to prevent, if possible, the ingress of air. Care must be taken, also, not to permit any of the fluid to escape into the peritoneal cavity, lest it should provoke fatal inflammation. Unless the cyst is adherent to the walls of the abdomen, as it may be, if old and large, the best plan will be to establish, as a preliminary measure, a caustic issue over the most prominent part of the swelling, as in the treatment of hepatic abscess. When any doubt remains, as to the strength of the adhesions, the abdomen should be well bandaged after the contents of the cyst are withdrawn, in order to confine the liver, and thus oppose an effectual barrier to peritoneal mischief. If the operation is followed by suppuration of the hydatid, the patient will be almost certain to perish from the resulting irritation.

Of 20 cases of this disease, treated by tapping, collected by Dr. Murchison, of London, 17 recovered, and 3 died; one from the development of secondary tumors, one from a miscarriage, and one from suppuration of the sac, the patient being moribund at the time of the operation.

Eight cases of successful treatment of hydatid tumors of the liver by electrolysis have been reported by Dr. Fagge and Mr. Durham. Two needles connected with the negative pole of a modified Daniell's battery of ten cells were passed into the cyst, the positive pole, terminating in a moistened sponge, being placed upon the surface of the abdomen. The current was maintained for a period varying from ten to twenty minutes in the different cases. The operation was generally followed by a rapid diminution of the tumor, together with slight febrile disturbance, and more or less pain, which, however, usually vanished in a few days. The duration of the treatment varied from two weeks to upwards of a month.

Serous Cysts.—Serous cysts may occur either in the substance of the liver, or upon its surface, immediately beneath the peritoneum, and are capable of attaining a large bulk, encroaching thus greatly upon the diaphragm and abdominal viscera, as well as upon the right hypochondriac and iliac regions. Like hydatids, they are generally of slow growth, and they may be either solitary or multiple, simple or multilocular. They are dull on percussion, fluctuate distinctly under the finger, and are generally unattended with pain and constitutional disturbance. Their contents are of a limpid, saline character, coagulable by heat, alcohol, and acids, thus differing essentially from those of hydatids. A serous cyst of the liver sometimes attains an enormous size. A few years ago I drew from a tumor of this kind, in a delicate

female, aged twenty-three, nearly a gallon and a half of fluid, as clear as spring water. No accident ensued, and she has remained well ever since.

A cyst of this kind might easily be confounded with a hydatid of the liver; in fact, the only mode of distinguishing between them is the use of the exploring needle. In a serous cyst the contents are always coagulable, whereas in a hydatid there is an absence of albumen. In both affections the fluid is saline, but less so in the former than in the latter.

A serous cyst may, like a hydatid, empty itself into a neighboring organ, or it may point externally, and ultimately open upon the abdomen, although such an occurrence must necessarily be very uncommon. When the fluid is poured into the peritoneal cavity, fatal inflammation speedily follows. The proper treatment, of course, is tapping, but not until there is reason to believe that the tumor is firmly adherent to the wall of the abdomen.

SECT. X.—INJURIES AND DISEASES OF THE GALL-BLADDER.

Wounds of the gall-bladder are almost invariably fatal. In fact, the only authentic instance, so far as I know, of recovery, is one mentioned by Parroisse, in which a man received a gunshot injury in the right hypochondriac region. He died at the end of two years of thoracic disease, when the ball was discovered in this reservoir. The period at which death occurs varies, on an average, from thirty-six to forty-eight hours. In a case recorded by Dr. Stewart, in which the gall-bladder was traversed by a sword, the patient lived seven days. On the other hand, Mr. Edlin met with an instance of bayonet wound of this sac, in which death was caused in thirteen hours.

Rupture of the gall-bladder is generally produced by falls, kicks, or blows, and may occur without any appreciable injury of the external surface of the body. A remarkable case, in which the gall-bladder was found separated from the liver, has been related by Dr. Kilgour. The injury, caused by a jump upon the abdomen, proved fatal in thirty-six hours.

Wounds and lacerations of the cystic, hepatic, and choledoch *ducts* are followed by the same disastrous consequences as similar lesions of the gall-bladder.

Extraordinary *distention* of the gall-bladder, from an accumulation of bile, concretions, or hydatids, is occasionally met with, and may present points of the deepest surgical interest. The affection is, for the most part, due to mechanical obstruction, either temporary or permanent, of the cystic or choledoch duct. The tumor thus formed varies in size from a fist to that of an adult's head. In a case related by Gibson, it contained eight pounds of inspissated bile, and was so large as to reach over into the left hypochondriac region, forcing out the ribs on both sides, and causing great embarrassment in breathing. Parallel examples have been recorded by other observers. The swelling is generally of a globular shape, with a smooth outline, and a distinct sense of fluctuation, especially when it is of unusual bulk, or, indeed, even when it is comparatively small, provided the abdominal walls are abnormally thin. Its most common situation is the hypochondrium, where it often projects below the cartilaginous margins of the right ribs; cases, however, occur in which it is most prominent in the epigastrium, towards the umbilicus, or in the iliac region. The contents of the distended gall-bladder do not always consist of bile. When its coats are inflamed, the fluid may be purulent, or pus may find its way into it from an abscess of the liver. In most instances there are biliary concretions; and examples have been recorded in which the fluid contained hydatids.

The tumor formed by a distended gall-bladder is free from pain and constitutional disturbance, and is generally very tardy in its development. When the obstruction upon which it depends is permanent, dyspeptic symptoms at length ensue, and the whole surface becomes deeply jaundiced. When the gall-bladder is very large, it may occasion great difficulty of breathing and other symptoms of mechanical embarrassment. The principal affections with which it is liable to be confounded are abscess, hydatids, and encysted tumors of the liver.

The importance of an accurate diagnosis in this disease is illustrated by the fact that a distended gall-bladder has occasionally been punctured under the supposition that the case was one of abscess of the liver. Such a mistake, which the

acute and sagacious Petit once came very near committing, would almost certainly be fatal.

A temporarily distended gall-bladder may relieve itself either spontaneously or under the influence of cholagogue remedies. When the obstruction, however, upon which the accumulation depends is permanent, the case will generally terminate in one of four ways: by rupture of the organ, and the effusion of its contents into the peritoneal cavity, by its adhesion to the intestine and the escape of the fluid in that direction, by the discharge of its contents through the wall of the abdomen, or, finally, by the induction of constitutional irritation.

The surgical treatment of this disease is limited to the puncture of the distended organ with a small trocar. But before such a procedure is undertaken, the operator should be perfectly satisfied that firm adhesions exist between the tumor and the walls of the abdomen, otherwise, some of the fluid passing into the peritoneal cavity, fatal results might ensue. In cases of doubt the proper plan is to excite adhesions in the same manner as in abscess of the liver. Frerichs mentions an instance in which a tumor of this kind was successfully tapped, about ten ounces of bile flowing off. It formed a very painful, tense, pear-shaped swelling, which pushed out the wall of the abdomen, and extended an inch and a half below the crest of the ilium.

SECT. XI.—INJURIES AND DISEASES OF THE SPLEEN.

Wounds of the spleen are still more rare than wounds of the liver, which they strictly resemble in their character and in the mode of their production. The prognosis is usually unfavorable, rather, on account, however, of the consequent hemorrhage than the severity of the resulting inflammation. All the cases of gunshot wounds that occurred during the late war were fatal. When there is a large opening in the side or abdomen, a portion of the spleen may protrude, thus affording an opportunity of ascertaining the true nature of the lesion by direct inspection; but, in general, the only phenomena which the practitioner has to guide him in the formation of his opinion of the case are, the situation of the external wound, the fixed nature of the pain, and the extreme pallor of the countenance, indicative of the great hemorrhage which is so liable to follow such accidents. The absence of symptoms of intestinal, gastric, and other lesions affords important negative evidence.

The treatment should be conducted upon general antiphlogistic principles, of which rest and light diet are among the most important. If copious hemorrhage exist, acetate of lead and opium should be administered in large and sustained doses, aided by the internal and local use of ice. Stimulants are employed warily, lest the reaction be great and sudden, reinventing hemorrhage, or hastening inflammatory development. If the wounded organ protrude, or lie within the edges of the outer opening, prompt replacement is effected, provided the wound is small, and not disposed to bleed much, otherwise it will be much better to let it remain in its impacted situation than to restore it to the abdominal cavity, as such a step would only serve to favor profuse effusion from the divided and now unsupported vessels. I am inclined to believe that most of the recoveries after lesions of this kind are due to the partial escape of the organ from the abdomen, and the compression of the wounded structures by the edges of the external orifice. Hence, the circumstance is to be regarded, at least sometimes, rather as a propitious than as an untoward occurrence. If the splenic artery is pierced or severed, the ligature must be employed, even at the risk of greatly enlarging the external wound.

A remarkable case of recovery after an incised wound of the spleen, attended with loss of a portion of the organ, is recorded by Leonardo Phioravante in his *Secrets of Chirurgery*, published at the middle of the seventeenth century.

Instances occur in which the spleen protrudes some distance beyond the external wound, in a state of severe inflammation, several days having, perhaps, elapsed since the infliction of the injury. The proper treatment, in such an event, is not to restore the projecting portion, lest it should mortify, or lead to dangerous hemorrhage, but to remove it, either with the knife or ligature, on a level with the surrounding surface. The propriety of this practice is sanctioned by the report of numerous cases in which it was successfully adopted; among others, by those of Macdonald, of India, and Dr. W. B. Powell, of Kentucky.

Professor Flint, in his *Treatise on the Practice of Medicine*, briefly describes a

case in which nearly the entire spleen protruded through a gunshot wound of the abdomen. A surgeon, on the third day after the accident, threw a strong ligature around the organ, on a level with the skin, and tightened it daily until the fourth day, when it dropped off. The stump which remained plugged up the bullet-hole. No suppuration ensued, and the man soon entirely recovered.

Rupture of the spleen is sometimes produced by the most trifling accidents, especially if there be considerable softening of its substance, as so frequently happens during the progress of intermittent fever. Under such circumstances, indeed, the organ has been known to give way spontaneously, or under the slightest violence, as a blow upon the abdomen, a sudden twist of the body, or straining at stool. The accident is usually fatal in a few hours from the loss of blood, which is often effused in immense quantities, and which no remedies can control. An instance of death from laceration of the splenic vein, caused by severe bodily exertion, in a man, twenty-six years of age, has been recorded by Dr. Miling.

The spleen is sometimes fatally ruptured by external violence without any apparent marks of injury of the abdomen. In 1867, a boy, seven years of age, died in less than half an hour after he had been struck by a piece of brick thrown at him by a man some distance off. An examination made by Dr. Shapleigh, of this city, showed that the spleen, enlarged in consequence of a former attack of intermittent fever, had been extensively lacerated, and that the peritoneal cavity contained nearly a quart of blood, the result of the injury.

Excision of the spleen, on account of chronic enlargement, is said to have been performed by Zaccarelli, in 1544, upon a man, twenty-four years of age. The incision was simple, and the wound healed in less than a month. The operation was not repeated until 1826, when it was executed by Quittenbaum, of Rostock, upon a woman, who died, apparently from shock, in six hours. The spleen weighed nine pounds. Dr. Küchler, of Darmstadt, who performed the operation in 1855, lost his patient, a man, thirty-six years old, from hemorrhage, within two hours. In a case under the charge of Mr. T. Spencer Wells, of London, in 1865, death occurred on the seventh day from pyemia. The patient was a woman, thirty-four years of age. The spleen, although it weighed upwards of six pounds, and was nearly a foot in length, was easily extracted through an incision, seven inches in length, carried along the external border of the left rectus muscle of the abdomen. The vessels were secured with silk ligatures, cut off short. Very little bleeding occurred. In a case of excision of the spleen performed in 1866, by Thomas Bryant, death occurred at the end of two hours. The abdomen contained a pound and a half of clotted blood. In 1867, Péan reported the case of a woman, twenty years of age, from whom he had removed two months previously, with complete success, an enlarged spleen, mistaken for an ovarian tumor. Köberle, in the same year, extirpated a hypertrophied and adherent spleen with a fatal result, the woman dying from hemorrhage on the table.

SECT. XII.—ABSCESSSES WITHIN THE WALLS AND CAVITY OF THE ABDOMEN.

Parietal Abscess.—It is not often that abscesses form in the walls of the abdomen. The occurrence is chiefly witnessed as a result of external injury, as a blow or kick, but it is also occasionally noticed as a consequence of inflammation of the bowel from the presence of impacted feces, or of a foreign body. However induced, the symptoms are usually well marked, being such as attend acute inflammation in other parts of the body, only that there are generally more pain and constitutional disturbance. The matter may collect, first, immediately beneath the skin, in the celluloadipose substance; secondly, between the layers of the different muscles; and, thirdly, between the muscles and the peritoneum. In the latter case, it is usually of a decidedly stercoraceous odor, owing to the imbibition of sulphuretted hydrogen from the intestinal tube, which is very apt, as the disease advances, to become adherent to the posterior wall of the abscess. This event often happens even when the bowel retains its integrity, as, indeed, it generally does, however extensive may be the accumulation, its tendency being always to the external surface. Owing, however, to the manner in which the pus is bound down by the muscles and aponeuroses, it is a long time in coming to a head.

The diagnosis of these deep-seated abscesses is sometimes extremely obscure, especially in their earlier stages. The most reliable phenomena are, the occurrence of rigors, alternating with flushes of heat, the indurated and circumscribed nature

of the swelling, the excessive pain and throbbing, and the existence of an erysipelatous blush of the surface, with marked œdema of the subcutaneous cellular tissue. The fluctuation is always very faint, even when the matter is approaching the surface. If the abscess is situated towards the middle line, it may receive an impulse from the aorta, and thus induce a suspicion of the existence of aneurism. Whenever there is any doubt about the diagnosis, recourse is had to the exploring needle.

The treatment is, of course, rigidly antiphlogistic; by venesection, leeching, and medicated poultices, along with the frequent application of iodine, and the use of purgatives, nauseants, and anodynes. As soon as fluctuation is perceived, or even before, provided there is no doubt respecting the diagnosis, a free incision is made, patency being afterwards maintained with the tent. If the matter is permitted to remain long pent up, it must necessarily lead to serious structural changes, rendering the cure very tedious.

Hepatic Abscess.—Abscesses within the abdomen are usually situated in the liver, their occurrence being very frequent in warm climates, especially in the East and West Indies. They are also sufficiently common among the boatmen of our southern rivers. During my residence at Louisville nearly a dozen cases of hepatic abscess, all from Louisiana, were admitted into the Marine Hospital of that city within less than two months. The matter may discharge itself in different directions; most generally, perhaps, into the peritoneal cavity, where, of course, it promptly excites fatal inflammation, or into a neighboring coil of intestine, into the lungs, or externally through the walls of the abdomen. It is only in the latter event that the disease ever calls for surgical interference, and it is evident that an early and correct diagnosis here is a matter of paramount importance. If the case be neglected, or misunderstood, the abscess, giving way, may suddenly burst into the peritoneal sac, and thus destroy a patient, who, under other and more favorable auspices, might be saved. Besides, if the fluid is long retained, it may cause irreparable injury to the hepatic tissues, so that, although it may ultimately find an external outlet, recovery will be impossible.

The most valuable diagnostic characters of hepatic abscess are, a severe, gnawing, aching, or throbbing pain in the hypochondriac and scapular regions, marked enlargement of the liver, great embarrassment of breathing, and inability to lie on the left side, accompanied by violent rigors, alternating with flushes of heat, excessive gastric irritability, and a muddy, jaundiced state of the eye and skin. As the matter accumulates and nears the surface of the organ, it excites inflammation in its peritoneal covering, causing adhesions between it and the wall of the abdomen. The morbid action steadily advancing, ulceration is set up in the superincumbent structures, leading, eventually, after weeks of suffering, to an escape of the fluid, its approach being always preceded by an erysipelatous blush, and by a doughy, œdematous state of the surface.

There are four circumstances in connection with abscess of the liver worthy of special attention.

1st. Care should be taken not to puncture the swelling until there is a well-marked red, purple, or livid spot, with an œdematous state of the skin and cellular tissue, over its most prominent part. If these phenomena are wanting, it may be assumed, as a general rule, that there is no adhesion between the liver and the wall of the abdomen, and, consequently, that, if an opening be made, the matter will inevitably flow into the peritoneal cavity, causing fatal inflammation.

2d. When the pus is slow in reaching the surface, and the symptoms are urgent, a free incision should be made over the more protuberant part of the swelling, through the abdominal muscles, but no farther, the object being to excite prompt and efficient adhesion between the contiguous surfaces, by means of a tent carried deeply into the bottom of the wound. As soon as this event has been brought about, the abscess may be opened with entire impunity.

3d. Care should be taken not to confound the disease with chronic distention of the gall-bladder, an accident which has, more than once, been followed by fatal results. The signs of distinction are generally sufficiently clear. In enlargement of the gall-bladder, the tumor is globular, uniformly hard, and situated lower down than in hepatic abscess; in which the swelling is more diffused, more painful, and also more soft, generally fluctuating at its summit, while at the base it is firm and resisting.

4th. The puncture in hepatic abscess should not be direct, but valvular, so as to

exclude the ingress of the air, the presence of which is always a source of severe irritation by causing rapid decomposition of the pus. To obviate this effect, the operation should be performed in the same cautious manner as in paracentesis of the chest, with a trocar having a canula furnished with a stopcock and a bladder. The only exception to this rule is where the matter lies immediately below the skin, ready at any moment to discharge itself.

The recent observations of some of the East India practitioners go to show that puncture of hepatic abscesses is a much more fatal operation than had generally been supposed. Of 81 cases, collected by Dr. Waring, of the Madras Army, 66 died, and only 15 recovered. Of 24 cases recorded by Dr. Morehead, two-thirds died. The cause of death in most of the cases was gangrene of the tissues around the puncture and of the subjacent structures. In a majority of the successful cases the abscess pointed either at the epigastrium or at the border of the right ribs above the level of the ninth.

Biliary Abscess.—Abscesses of the gall-bladder opening outwardly are uncommon. Their exciting cause is usually external injury, or some mechanical obstruction to the evacuation of the bile, which thus, in consequence of its irritating properties, sets up inflammation, terminating in suppuration. As the case progresses, adhesions form between the affected organ and the walls of the abdomen, and these, in turn, are succeeded by ulcerative action, and the discharge of the matter.

The manner in which such an abscess is developed is usually very insidious; and, as to its diagnostics, they are altogether unreliable. The affections which it is most liable to simulate are abscess, hydatids, and serous cysts of the liver, and from these it is seldom in the power of the surgeon to distinguish it until he meets with the characteristic discharge; that is, bile mixed with pus, or pus and gall-stones. Deep jaundice, gastric irritability, clayey stools, and high-colored urine are prominent symptoms in the latter stages of the complaint. The abscess generally points in the lower part of the hypochondrium, but a long time commonly elapses before it reaches the surface. In some cases, the matter pursues a very long and devious route before it finds an outlet. Its approach is always preceded by great pain and tenderness, and by an erysipelatous appearance of the integument.

Gall-stones sometimes pass off by these abscesses, occasionally in large numbers, followed by a good recovery, as in a case which I saw, along with a former colleague, Professor Miller, of Louisville. The patient, a lady, aged forty-one, had suffered for several years from severe pain in the right hypochondrium, with inability to lie on either side, but especially the left. After some time a hard, circumscribed swelling, about the size of an egg, appeared at the most tender part, and, at length, terminated in an abscess, which, breaking externally, gave exit, at various intervals, altogether to thirty-six biliary concretions, of a tetrahedral figure, perfectly smooth, of a dark cinnamon color, and about the volume of an ordinary cherry. The mouth of the abscess was situated on a level with the umbilicus, five inches from the middle line. In a case more recently under my observation, nine calculi, the largest upwards of half an inch in diameter, were discharged from an abscess in the right side, the patient, a woman, thirty-eight years of age, making an excellent recovery.

The treatment of biliary abscess must, in the first place, be rigidly antiphlogistic, as in abscess of the liver. Surgical interference should be refrained from until the matter fairly points, or until there is reason to believe, from the character of the local symptoms, that firm adhesions have formed between the gall-bladder and the wall of the abdomen. If this precaution is neglected, the fluid may pass into the peritoneal cavity, and thus provoke fatal inflammation.

Stercoraceous Abscess.—This variety of abscess, which, as the name implies, is connected with the intestinal tube, may occur in any portion of the abdomen, but is most common in the right iliac region, from disease of the colon, cæcum, or vermiform appendix, brought on by the abuse of purgatives, the impaction of foreign bodies, or external injury. Cases occur in which it is due to perforative ulceration of the bowel, as a result of typhoid fever; but the most common cause of all is the lodgment of an extraneous substance in the cæcal appendix, as a fruit-stone, nail, shot, bristle, worm, inspissated mucus, or calculous concretion. Sometimes the obstruction is occasioned by indurated feces, dry, brittle, and, perhaps, incrustated with carbonate and phosphate of lime. Whatever its character may be, it is sure, if long retained, to excite irritation and ulceration in the coats of the appendix,

followed by adhesions, and ultimately, if the morbid action is not checked, by the development of a stercoraceous abscess, opening externally, into the peritoneum, into some neighboring coil of intestine, or even into the urinary bladder.

The pus attending the formation of an abscess of this kind is generally of an ill-elaborated character, and excessively fetid, owing either to the absorption of sulphuretted hydrogen from the alimentary canal, or the actual admixture of fecal matter, which sometimes escapes in large quantities.

The disease, although most common between the ages of ten and thirty-five, occurs at all periods of life, sometimes even in very young subjects. Males are much more liable to it than females.

The symptoms of stercoraceous abscess are always well marked, being invariably such as characterize the development of phlegmonous abscess in other parts of the body. The local distress, however, is generally more than ordinarily severe, owing to the resistance which the accumulating pus encounters from the surrounding structures. The swelling is deep-seated, very painful, and extremely tender on motion and pressure, and there is nearly always marked œdema of the right thigh and leg from obstruction to the return of the blood in the iliac vein. Great constitutional disturbance is present; the rigors are violent and protracted, and the patient is harassed with gastric irritability, want of sleep, a sense of excessive prostration, tympanites, and constipation occasionally alternating with diarrhœa. Sometimes the vomiting is stercoraceous, indicating intestinal obstruction from pressure of the overlapping tumor. As the matter advances, the integument is elevated into a distinct tumor, exquisitely tender to the touch, and characterized by an erysipelatous blush, with an appearance of œdema, both so characteristic of deep-seated abscess. Owing to the manner in which the fluid is bound down, it is seldom possible to detect fluctuation until after the disease has committed severe, if not irreparable, mischief. In some cases air passes from the bowel into the abscess, where its presence may readily be detected both by the ear and the finger, the part, on percussion, emitting a peculiar tympanitic sound. Valuable information is generally afforded by the use of the exploring needle.

The treatment of this affection is by an early and free incision; for, unless the case be met in this way, the matter will be sure to burrow more or less extensively, and may even find vent by the bowel, thus eventually causing a stercoraceous fistule, since, notwithstanding this occurrence, the abscess will ultimately also discharge itself externally. Before the operation is performed, the nature of the disease should always be carefully explained to the patient and his friends, lest, gas and pus escaping, the surgeon be accused of having wounded the bowel, when the opening has been made by the pressure of the pus, or the ulceration which preceded and caused the abscess.

Splenic Abscess.—Abscess of the spleen should be treated upon the same principles as that of the liver. Of this rare disease I have seen only one case, the patient being a young, robust farmer, who suffered immensely for a fortnight. The spleen gradually augmented in volume, and, at the expiration of this period, it projected over towards the umbilicus, forming a large, rounded tumor, between the linea alba and the margin of the ribs. In a short time fluctuation was perceived, and, on introducing a trocar, about three pints of fetid, dark-colored matter issued from the incision. The wound was kept open for several days, by means of a tent; but it soon closed, and, thence on, the patient's health began gradually to improve. The disease had supervened upon repeated attacks of intermittent fever, and was characterized by excessive irritability of the stomach, great pain and tenderness, and an impending sense of suffocation, caused, no doubt, by the pressure of the enlarged organ upon the diaphragm.

The abscess most generally bursts into the peritoneal cavity, the stomach, colon, or small bowel. Occasionally the spleen becomes adherent to the diaphragm, and then the matter may find an outlet through the lungs, as in the interesting cases observed by Nasse, Mantell, and other practitioners.

The metastatic abscess of the spleen is much less common than that of the lung, liver, or brain. It is usually multiple, small, and imperfectly elaborated, being composed, in great degree, of bloody matter interspersed with pus globules.

Ilio-Pelvic Abscess.—Finally, there is a form of abscess which occasionally supervenes upon parturition, coming on within the first fortnight after delivery, in

consequence of inflammation of the uterus. It differs from the more ordinary abscess in the iliac region in that the matter is situated lower down towards the anterior superior spinous process of the ilium, or even in the ilio-inguinal region, the fluid extending, perhaps, slightly beneath Poupart's ligament. Very frequently, indeed, the matter is strictly lodged in the pelvis, its starting point being, probably, the broad ligament of the uterus, the ovary, or the retro-peritoneal cellular tissue. However this may be, the disease is much more common on the left than on the right side.

An abscess of this kind is fraught with danger, the patient being generally worn out by the intensity of her suffering. Occasionally, however, a recovery takes place, the matter eventually finding an outlet at the upper and external part of the groin, near Poupart's ligament, the opening usually remaining fistulous for a long time. Now and then the abscess empties itself into the rectum, vagina, uterus, bladder, or abdominal cavity. In chronic peritonitis, as well as in pelvic cellulitis, the pus has been known to extend along the spermatic cord, and finally to point at the external ring.

When the abscess points in the posterior cul-de-sac of the roof of the vagina, as denoted by the soft and yielding character of the part, it may be punctured with the bistoury, guided by the forefinger, or, what is usually preferable, a long, curved trocar. Great care must, of course, be taken not to wound any important structures. The manner of performing the operation is well shown in the annexed sketch, fig. 488, from Simpson.

Fig. 488.



Mode of Puncturing Pelvic Abscess.

SECT. XIII.—TUMORS IN THE WALLS OF THE ABDOMEN.

Various morbid growths, benign and malignant, form within the walls of the abdomen, and, although they do not differ from those in other regions, they deserve particular attention, from the peculiarity of their situation, and their liability to be mistaken for tumors developed in the cavity of the abdomen. The principal growths in this situation, demanding brief notice, are the fatty, sarcomatous, and cystic. Carcinomatous tumors of the walls of the abdomen are exceedingly uncommon. Encephaloid and melanosis are the only heterologous formations that I have ever met with here, and they were both easily recognized; the first by the rapidity of its development and great bulk, and the second by its black color, which was distinctly visible under the skin, where the carcinomatous tubercles were situated.

The *fatty tumor* is not often found in this situation; it may lie immediately beneath the skin, among the muscles, or in the inguinal canal. When it occupies the site of the natural outlets of the abdomen, or the linea alba, it may be confounded with hernia, as in the interesting case of Scarpa, in which that illustrious surgeon was induced to perform an operation, under the supposition that his patient was laboring under strangulation of the bowel, when he had merely some colicky pains and abdominal tenderness. Had due inquiry been made into the history of the case, such a mistake might easily have been avoided.

The diagnostic characters of the fatty tumor are, the tardiness of its growth, its perfect indolence, or freedom from pain, its doughy, inelastic feel, the absence of discoloration of the skin, and the integrity of the general health.

A *sarcomatous* tumor is occasionally met with in the walls of the abdomen. An interesting case of this kind was brought under my notice in 1858, at the College Clinic, in a youth of eighteen. When first perceived, thirteen months previously, it was hard and firm, but perfectly movable, and about the size of a pullet's egg, its situation being on the left side, some distance from the umbilicus. Its progress, for several months, was very gradual, but during the last six or eight weeks it had increased rather rapidly, and, when the case fell into my hands, the growth was about nine inches in length, solid, inelastic, almost immovable, free from pain, and without any enlargement of the subcutaneous veins, or derangement of the general health. A curvilinear incision being carried down over the long axis of the tumor, it was found to be placed under cover of the abdominal muscles, which were very much

stretched and attenuated, its posterior boundary being formed by the transverse fascia, from which it was obliged to be separated with great care. Its chief supply of blood was derived from a branch of the superficial epigastric artery, which was enlarged and required a ligature. Under the microscope, the tumor exhibited all the characteristics of spindle-celled sarcoma. The recovery from the operation was rapid, and, thus far, there has been no tendency to relapse.

The *cystic tumor* of the walls of the abdomen is very uncommon. In most of the cases that have hitherto been observed, it was deep-seated, lying immediately exterior to the peritoneum. It fluctuates, although usually rather faintly, under pressure, and is capable of attaining so large a bulk as to simulate ascites, or ovarian dropsy. Its contents are of a serous nature. Its progress is very slow and painless, and the patient's health is commonly excellent. These circumstances will generally serve to distinguish this morbid growth from others of a more solid character, but, if any doubt exist upon the subject, it will promptly be dispelled by the use of the exploring needle. An instance in which three immense cystic tumors existed simultaneously in the walls of the abdomen, has been related by Dr. Scott in the eleventh volume of the London Medical Gazette.

In the *diagnosis* of tumors of the walls of the abdomen, much valuable information may be derived from a careful consideration of the history of the case, and a thorough examination of the parts, the bowels having been freely evacuated a short time previously. The patient should lie upon his back, with his limbs well retracted, and the shoulders elevated, so as to cause complete relaxation of the abdominal muscles. The tumor being now grasped with one hand, the fingers of the other may generally be readily insinuated beneath it, if it be situated in the abdominal walls, at the same time that it will convey an idea of fixedness, which does not belong to intraperitoneal growths. If the patient turns upon his side, the tumor will steadily maintain its position; generally, too, there will be a degree of tension in the parts which is altogether foreign to internal formations and enlargements. In the intraperitoneal tumor, no matter what may be its character, the growth is originally loose, usually moving or floating about when the patient changes his position in bed; in the extraperitoneal, on the contrary, it is fixed. A growth situated in front of the muscles of the abdomen becomes more prominent when these muscles actively contract; no change is produced by this cause when the tumor is developed in the substance of the muscles; when the morbid mass lies behind the muscles, it is forced backwards at each effort, and thereby rendered less distinct. When a tumor follows all the motions of the walls of the abdomen, whether dependent upon respiration, pressure, or traction, the presumption is that it was developed there; but when it does not obey them, the probability is that it is situated behind them, or, what is the same thing, that it has no connection with them. The diagnosis between a tumor and an abscess is readily determined by the history of the case, and the absence or presence of inflammatory symptoms. If any doubt exist in regard to the precise position of the morbid growth, and an operation be urgently demanded, an exploratory incision will be the only thing likely to clear up the difficulty.

In the *extirpation* of tumors in this situation, the incision should always be made as much as possible in the direction of the muscular fibres of the abdomen; free use should be made of the grooved director; all bleeding vessels should be tied as soon as they are divided; and unusual pains should be taken to tack together, first, the muscular edges of the wound, and afterwards the integumental, lest, when the parts are healed, hernia should take place. The abdomen should be well protected with long, broad adhesive strips, aided by a compress and broad bandage, which, when the patient is about to rise, should be replaced by an elastic supporter, to obviate all danger of visceral protrusion.

When the tumor is cystic, the best plan is to evacuate its contents by a free incision, and then mop its inner surface thoroughly with dilute tincture of iodine.

Professor Nélaton, in 1862, described with great accuracy what he calls the fibrous tumor of the *iliac fossa*, a growth which I have myself never met with in this situation. It usually occurs in young married women, closely resembles in its structure the fibrous tumor of the uterus, and is situated just above Poupart's ligament, near the anterior superior spinous process, where it is generally, if not invariably, connected by a fibrous band to the iliac bone. It is solitary, hard, elastic, tardy in its progress, and easily pushed a little upwards and backwards, but not downwards or inwards. In volume it varies from a fist to that of a foetal head. The accompany-

ing pain is of a lancinating character, and extends about in different directions, especially down the thigh and leg. The skin retains its natural color and consistence. The tumor is developed in the cellular tissue between the peritoneum and the iliac fascia.

In examining such a tumor care should be taken not to confound it with an enchondroma of the iliac bone, a fibrous tumor of the uterus, a collection of feces, a glandular enlargement of the groin, or a tertiary syphilitic tumor in the wall of the abdomen. Its most important characteristics are its remarkable firmness, the fact that it is always solitary, its great depth and fixedness in the iliac region, the lancinating nature of the pain, its slow growth and small size, and, finally, the absence of oedema and discoloration of the skin. The general health commonly remains sound.

If the tumor is small, free from pain, and slow of growth, it should be let alone; otherwise it may be removed, care being taken, in laying it bare, not to wound the peritoneum and the iliac vessels. The incisions should be made in the direction of Poupart's ligament.

SECT. XIV.—ASCITES OR DROPSY OF THE ABDOMEN.

Ascites is a collection of watery fluid in the cavity of the abdomen, generally the result of mechanical obstruction to the return of venous blood. The immediate causes of this obstruction are usually valvular disease of the heart, enlargement of the liver, spleen, ovaries, uterus, omentum, and mesenteric glands, organic affections of the kidneys, closure of the vena cava by fibroid concretions, cirrhosis, carcinoma and hydatids of the liver, and chronic inflammation of the peritoneum. Suppression of the cutaneous perspiration from the effects of cold may also give rise to it. An impoverished state of the system, however induced, whether the direct result of the loss of blood, inadequate supply of food, or protracted and exhausting disease, as scarlatina, measles, and typhoid fever, may be enumerated as so many predisposing causes of ascites. The malady occurs in two varieties of form, the acute and chronic.

The fluid of ascites is generally of a pale amber color, slightly viscid, saline, and strongly albuminous. When the peritoneum is actively inflamed, it may be reddish, and intermixed with pus and lymph. In organic disease of the kidneys it occasionally exhibits traces of urea, and crystals of cholesterine are also sometimes seen in it. In quantity it ranges from a few ounces to many quarts, from two to three gallons being the average when surgical interference is demanded.

The *symptoms* of this complaint are usually well marked. Among the earliest and most prominent is a gradual failure of the general health; the flesh and strength decline; the countenance is pale and wan; the abdomen progressively enlarges; the renal secretion diminishes; and the lower extremities swell and pit on pressure. As the accumulation increases, the fluid encroaches more and more upon the bowels and other viscera, which, in their turn, press upon the diaphragm, pushing it up against the lungs and heart, and thus causing mechanical obstruction to respiration and circulation. The breathing is often exceedingly embarrassed, so much so, indeed, that the patient is unable to lie down; the action of the heart is irregular; the pulse is abnormally feeble and frequent; the appetite is impaired; the bowels are constipated; the urine is scanty, and not unfrequently loaded with albumen and renal casts; the distention of the abdomen steadily augments; the skin is harsh and dry; the emaciation becomes excessive; the scrotum, penis, walls of the abdomen, thighs, and legs are infiltrated with serum; and the patient at length, after, perhaps, the lapse of several months, dies, in a state of complete exhaustion. The blood, in chronic ascites, is always remarkably thin and watery. In the acute form of the malady, the symptoms are more severe, the accumulation advances more rapidly, and there is usually active febrile disturbance, with marked tenderness of the abdomen. Fluctuation is always present, even when the quantity of fluid is comparatively small. The tumor is diffused, and soft to the touch.

The situation of the cause of the disease may often be satisfactorily inferred from the manner in which the dropsy commences. When it depends upon organic lesion of the heart, lungs, or pleura, the first evidence usually is swelling of the head, face, trunk, and upper extremities; when the obstruction exists in the abdominal viscera, the swelling begins in the belly, and thence gradually extends to the legs and feet;

and when it is caused by mere debility, as a sequel of exhausting disease, it always manifests itself originally in the lower extremities, or the most dependent portions of the body.

The *diagnosis* of ascites is generally sufficiently easy. A thorough examination of the abdomen and pelvis, and a careful consideration of the history of the case, will rarely mislead the practitioner. The affections with which the complaint is most liable to be confounded are, pregnancy, ovarian dropsy, chronic tympanites, and distention of the urinary bladder.

From *pregnancy*, ascites may generally be easily distinguished by the history of the case; by the absence of the ordinary signs of utero-gestation; by the fluctuating nature of the swelling; by the subsidence of the fluid to the more dependent portions of the body, on varying the posture of the patient; and, lastly, by the effects of hydrogogue medicines. In pregnancy, the tumor is median in situation, hard and firm, not soft and yielding, as in ascites; and, as it advances, it is easy to detect the pulsations of the fetal heart and of the placenta. In pregnancy, the general health is usually good; in ascites, more or less impaired.

In *ovarian dropsy*, the tumor generally begins at one side, and becomes median only after it has acquired considerable bulk. In ascites, on the contrary, it is median from its commencement. In the former, the swelling is circumscribed, hard, tense, and protuberant; in the latter, diffused, soft, and fluctuating. In *ovarian dropsy*, the tumor, if unadherent, may be pushed about, but its contents always follow the sac; in abdominal dropsy, on the contrary, the situation of the fluid varies with the posture of the patient; in the one, the tumor lies in front of the bowels; in the other, the bowels are behind and above the fluid. In *ovarian dropsy*, the disease progresses slowly, and there is, for a long time, little or no disorder of the general health; in ascites, it proceeds more or less rapidly, and the system always deeply sympathizes with the local affection. When the cyst is multilocular, the surface of the tumor is commonly irregular, and, on being percussed, yields a sensation as if it contained liquids of different degrees of consistence. Finally, in *ovarian dropsy*, the uterus is often drawn up, or to one side, almost beyond the reach of the finger; in ascites, on the other hand, it occasionally retains its normal position.

The discrimination between ascites and chronic *tympanites* is not difficult. The torpid state of the bowels, the rumbling noises, the peculiar resonance of the entire abdomen under percussion, and the unvarying form of the tumor when the patient changes his posture, are too distinctive to be mistaken. The history of the case will, of course, afford additional light.

It seems difficult, at first sight, to suppose that any one could mistake a hugely distended *bladder* for ascites, and yet such an error has, doubtless, occasionally been committed. It is reported of John Hunter that he punctured a distended bladder, under the belief that the patient was laboring under ascites. The signs of distinction are, the history of the case, the median situation of the tumor, the absence of distinct fluctuation, the immovable position of the swelling, the constant dribbling of fluid from the urethra, especially if the retention has existed for some time, the peculiar character of the pelvic pains, the bulging of the bladder into the rectum, and the urinous odor of the body. If any doubt obtains, it will be promptly dispelled by the insertion of the catheter.

Other causes of embarrassment may exist, as hypertrophy of the liver and spleen, disease of the omentum, dropsy of the uterus, hydatids of the liver, excessive enlargement of the stomach, cystic growths of the Fallopian tubes, dropsy of the kidney, and cystic tumors in the walls of the abdomen. The merest allusion to these sources of deception will be sufficient to induce the surgeon to exercise the utmost vigilance in all cases of a doubtful character.

Allusion has already been made to the manner in which the fluid in ascites changes its situation with the posture of the patient. This is a most important fact in relation to the diagnosis of the disease. When the patient lies down, the fluid sinks back, and presses out the flanks; when he is erect, it gravitates towards the pelvis and lower parts of the abdomen; and when he lies on one side, it becomes more conspicuous on the other. Fluctuation is always readily detected by alternate pressure made with the hands or fingers, applied at opposite points of the abdomen. The situation of the intestines is determined by the peculiar resonance elicited on percussion. Whenever there is fluid, there must necessarily be dullness.

There are two circumstances in reference to the situation of the intestines worthy

of special notice in relation to ascites. The first is that they cannot float upon the liquid when they are loaded with solid matter, or are entirely free from gas; and the second, that they may be so firmly bound down by ancient adhesions as to prevent them from rising to the surface. Under such circumstances, the diagnosis between ascites and ovarian dropsy might not only be difficult, but even impossible.

When the accumulation of water is excessive, it may exert so great a degree of pressure upon the recto-vaginal portion of the peritoneal sac as to cause the perineum to bulge out in the form of a tumor, from the volume of an orange to that of a foetal head. It is of an irregularly oval figure, like the urinary bladder, fluctuates distinctly under the finger, disappears temporarily on pressure, is more or less translucent, and projects forward in such a manner as to occlude the orifice of the vagina.

The *prognosis* of ascites is, for the most part, unfavorable, especially when the affection depends, as is so frequently the case, upon organic disease of an important organ, as the heart, lung, liver, or spleen. The milder forms occasionally recover spontaneously, or under the influence of very simple remedies.

In the *treatment* of ascites, the first object should be to ascertain, and, if possible, to remove, the exciting cause of the complaint, whatever this may be. The fact should be prominently kept in view that the collection of water is merely a symptom of disease, and not the disease itself. Unfortunately the prognosis is, for the most part, for this very reason, unfavorable. If the water be removed, whether by medicine or puncture, it will be sure, sooner or later, to reaccumulate, unless the cause under the influence of which it has been effused is effectually eradicated. In the earlier stages of the affection, a great deal may frequently be accomplished in the way of relief, by attention to the diet and secretions, and by the exhibition of what are called sorbefacient remedies, as some of the preparations of mercury, hydrogogue cathartics, acetate and nitrate of potassa, squills, cream of tartar, diuretic drinks, and, above all, elaterium. Of course, much judgment is required in the selection and use of these remedies. Mercury, in particular, although often exceedingly valuable, should be employed with the greatest possible care, as the slightest ptyalism could hardly fail to be injurious. The dose of elaterium should not, on an average, exceed the one-twentieth of a grain, repeated once or twice in the twenty-four hours. Tonics are generally necessary, and are sometimes productive of much benefit.

When the accumulation of fluid is very considerable, as when it amounts to several gallons, no medication, however judiciously directed, will be likely to be of any avail, owing to the inability of the absorbent vessels to exert their specific influence; and then the only thing that can be done, with any prospect of success, is to draw off the fluid by an operation, the manner of performing which will be described in the next section.

SECT. XV.—PARACENTESIS OR TAPPING OF THE ABDOMEN.

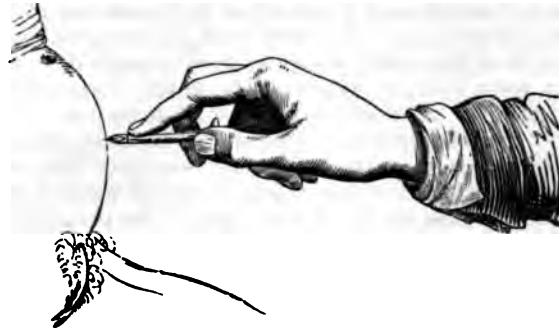
Tapping of the abdomen is required for the removal of dropsical accumulations of the peritoneum and the ovary. As it is generally intended merely as a palliative measure, it is never resorted to until the quantity of fluid is so considerable as to occasion great local inconvenience and serious embarrassment of respiration. It may be performed at various points, but the most eligible one is the linea alba, midway between the pubes and the navel. The only objection to puncturing the abdomen here is the danger of perforating the urinary bladder, which, when distended, often rises some distance above the pelvis. Any mischief, however, that might be thus induced will be effectually obviated by previous evacuation of the organ. In encysted dropsy, it may be necessary to make the opening at the side of the abdomen; but in doing this there is danger of wounding the epigastric artery, an accident occasionally followed by fatal results. In ordinary dropsy, the intestines are pushed back by the weight of the fluid, beyond the reach of the trocar. It is only when they have contracted adhesions to the anterior wall of the abdomen, as might happen when the operation has been repeatedly performed at the same place, that they would be at all likely to suffer. The fluid of ascites may sometimes be safely and expeditiously evacuated by puncturing the navel or the sac of an old umbilical hernia.

The only instrument required for this operation is a medium-sized, cylindrical trocar, which I greatly prefer to the flat. Some surgeons use a thumb-lancet or a bistoury and a catheter, but the operation thus performed, while it really possesses

no advantage whatever over the other, is always more painful and tedious. There should be at hand, in addition to the trocar, a broad flannel, muslin, or linen bandage, split at the ends, for swathing the belly, and several basins for receiving the water.

The patient sits semierect in bed with his feet on a chair, or, what is generally preferable, especially if he is weak, he lies on his side near the edge of the bed, and the abdomen is surrounded by the bandage, the ends of which are crossed behind, and given in charge of two assistants. Holding the trocar firmly in the right hand,

Fig. 489.



Operation of Tapping the Abdomen.

with the thumb and index-finger resting upon the canula, the surgeon plunges it into the linea alba, about three inches above the pubes, and, by a steady, forcible pressure, pushes it through the abdominal walls. A sudden cessation of resistance and the escape of a few drops of fluid announce the arrival of the instrument in the peritoneal cavity, and serve as a signal for the withdrawal of the trocar. The water issues in a full stream, and the discharge is usually soon completed. To prevent syncope, sometimes following the rapid removal of the pressure of the accumulated fluid, the ends of the bandage are gradually tightened by the assistants, which compensates, in some degree, for the loss of support experienced by the diaphragm, the large vessels, and the abdominal viscera. Occasionally the passage of water is interrupted by the intrusion of a piece of omentum, a hydatid, or a mass of lymph within the canula. When this happens, the obstacle should be removed by a director, a large probe, or a female catheter, the latter of which may sometimes be advantageously retained in the abdomen until the discharge is completed. When the operation is over, the canula is carefully withdrawn, and the puncture is closed with adhesive strips, the ends of the roller being firmly pinned over a thick compress to afford due support to the parts, and to prevent rapid reaccumulation. Union usually occurs in a few days.

The only accidents at all likely to happen in this operation are syncope and hemorrhage. Of these, the first is to be prevented by a proper tightening of the bandage, in proportion as the water is evacuated, and the second, by making the puncture at the linea alba, where there is no important vessel. It is possible that a copious hemorrhage may occasionally proceed from injury of one of the arteries of the omentum; but such an occurrence must be very rare, and does not, of course, admit of any remedy, since the true nature of the case will seldom be revealed until after death. Should the epigastric artery be wounded, and the blood issue externally, the opening made by the trocar should be plugged with a bougie, or piece of wood, wrapped with linen. This expedient failing, the vessel is exposed, and included in a ligature. Peritonitis after this operation is a remote contingency, and hardly deserves to be taken into account as one of its dangers.

A few examples have been recorded in which the trocar in this operation was accidentally thrust into the bowel. Such an occurrence is best avoided by carefully ascertaining beforehand the precise situation of the tube by the resonant sound emitted on percussion of the abdomen. A case has been published by Mr. Gay, of London, where the patient made a good recovery after such an accident.

When the surgeon is called upon to tap a female, especially a young, unmarried one, or one whose husband has long been absent, he should not be too eager to enter

upon the undertaking, but assure himself well beforehand that the patient is not laboring under pregnancy, instead of ascites. For want of this precaution, accidents have often occurred, as ludicrous as they were disreputable. The best way to avoid this "dry tapping," is to institute a careful examination into the condition of the mouth and neck of the uterus, if not also of the nipple, and to auscultate the abdomen, with a view to the detection of the fetal and placental sounds; or, what is still better, to employ the vaginoscope of Dr. Routh, an instrument which, brought directly in contact with the womb, reveals the placental souffle at a much earlier period, as from the eighth to the thirteenth week of gestation. This precaution will be more particularly necessary, if the patient is in excellent health, and has, withal, a ruddy complexion, phenomena which, as before stated, are never present in well-established ascites. If pregnancy exist, the hand, plunged into cold water, and suddenly applied to the tumor, will generally cause instantaneous motion of the child, thus at once revealing the true nature of the case. "I will give you," says Gooch, speaking of the doubtful signs of pregnancy, "a little advice as to the unmarried class. Never give an opinion until six months have elapsed since the last menstruation. Do not believe one word they say."

Great prejudice used to be entertained against tapping during pregnancy, and there is no doubt that the operation is occasionally followed by the premature expulsion of the child. A number of cases, nevertheless, are upon record in which it was performed with perfect safety even as late as the seventh or eighth month. Perhaps the most judicious plan is always to wait, if possible, until after delivery.

SECT. XVI.—FISTULES OF THE ABDOMEN.

The abdomen is liable to different kinds of fistules, of which the principal are the gastric, intestinal, and biliary. Generally caused by wounds, ulceration, or gangrene, they give rise to various accidents, and always heal with great difficulty; indeed, in many cases, they effectually resist every method of treatment that has yet been devised for their relief.

1. *Gastric Fistule*.—A gastric fistule generally occupies the epigastric region, and is, consequently, always very short. Although various kinds of injury may produce it, the more severe and unmanageable forms are usually the result of gunshot wounds, attended with more or less loss of substance of the muscular structure of the abdomen. In the case of Alexis St. Martin, the fistule was occasioned by a charge of buckshot, which, tearing away the integument at the inferior part of the left side of the chest, opened the pleural cavity, and entered the great cul-de-sac of the stomach through the diaphragm. The immense gap thus made gradually cicatrized, but left a permanent opening, about four-fifths of an inch in diameter, which is usually closed by a circular fold of protruding mucous membrane. Upon pushing back this valve-like fold, the contents of the stomach may readily be extracted for examination.

A fistule of the stomach is generally easily distinguished by its situation, and by the nature of its discharges, consisting of mucus, gastric juice, and various kinds of ingesta. Flatulence and dyspepsia are usually present in greater or less degree.

A gastric fistule, caused by organic disease of the stomach, is, of course, incurable; and a similar remark is applicable to all attacks of this kind, accompanied with great loss of substance. Closure, on the contrary, may reasonably be hoped for when the sinus is very small; for then restoration is sometimes effected spontaneously, or under very simple treatment. The most appropriate local remedies, apart from cleanliness, are stimulating injections, and occasional cauterization with nitrate of silver. Little, if, indeed, any, benefit is to be expected from refreshing the edges of the breach, and approximating them by suture. Special attention should be paid to the patient's diet and the condition of his system. When, in consequence of extraordinary loss of substance, the case is irremediable, the parts should be made as comfortable as possible by means of a suitable obturator. St. Martin, whom I saw upwards of twenty-five years after his accident, had all along enjoyed excellent health, and really did not seem, at the time referred to, to experience any material inconvenience.

2. *Biliary Fistule*.—Biliary fistule is usually caused by ulceration of the gall-bladder, leading to adhesion between this reservoir and the wall of the abdomen, the primary disease itself being produced either by ordinary inflammation, or by obstruc-

tion of the cystic duct by inspissated bile, a biliary concretion, or the pressure of some tumor. A similar effect may be occasioned by an abscess of the liver opening externally, or by gunshot and other wounds of this organ.

The most common situation of the fistule is the right hypochondriac region, but cases occur, although they are rare, in which it is found lower down or farther in towards the middle line. Its course is generally somewhat devious, and its diameter so small as hardly to admit a common-sized quill, especially if some time have elapsed since its formation.

The discharge from a biliary fistule consists either of pure bile, or of bile mixed with pus and mucus, the quantity in the twenty-four hours varying from a few drops to several drachms, according to the size of the sinus. Sometimes a probe may readily be passed along the abnormal passage into the gall-bladder or into a hepatic abscess. The general health is usually a good deal disordered, the patient being sallow, flatulent, dyspeptic, constipated, and colicky.

In a case which I attended with Dr. S. C. Sharp, of Kensington, the patient, a woman of forty-eight, had labored under a biliary fistule for nearly five years. It had been caused by a large hepatic abscess, followed by the discharge of seventeen calculi, varying in size from a pea to that of a horse-chestnut, with a smooth surface, and of an irregular, triangular shape. Their composition was chiefly cholesterine. Mucus and pus, mixed with bile, continued to flow from the side for upwards of four years, when the discharge materially diminished, but the pain and distress greatly increased. A probe inserted into the sinus readily detected two concretions, which I removed by enlarging the passage with a blunt-pointed bistoury. They were each about the size of a small nutmeg, and were situated in a pouch two inches and a half below the surface. No untoward symptoms followed. In a case reported by the late Professor March, of Albany, a concretion the size of a hickory-nut was lodged in the posterior part of the right iliac fossa, from which it was removed by an operation.

In the treatment of this affection little benefit is to be expected from topical means. Now and then a spontaneous cure takes place, but the great majority of instances remain unrelieved, and the patient is either worn out by the concomitant irritation, or dies of some intercurrent disease, perhaps years after the appearance of the fistule. All cases depending upon permanent obstruction of the cystic duct must necessarily be of this nature. Any plastic operation would, of course, be utterly futile; for, independently of the impossibility of reaching the bottom of the abnormal passage, the constant exit of bile would inevitably be fatal to the adhesive process. Any gall-stones that may appear in the fistulous track must be promptly extracted.

3. *Intestinal Fistule.*—Intestinal fistule, generally, but improperly, termed artificial or abnormal anus, is usually the result of gangrene of the bowel from the pressure exerted upon it by the stricture in strangulated hernia. It may also follow upon a wound of the bowel, and upon stercoraceous abscess. However produced, it is most frequently met with in the inguinal, scrotal, and femoral regions, in connection with the small bowel. A bad form of fistule occasionally arises from ulceration of the cæcum or vermiform appendix.

In the fistule caused by mortification, consequent upon strangulated hernia, the two ends of the bowel lie in immediate contact with each other, in the bottom of the sac, like the tubes of a double-barrel gun, their junction being formed by their contiguous walls, each, of course, consisting of four layers. During the inflammation which precedes the sloughing process, the outer or serous surfaces become firmly adherent, not only to each other, but also to the edges of the opening in the abdomen; hence, when the bowel gives way, there is no danger of fecal extravasation into the peritoneal cavity. The junction of the two cylinders here referred to forms a kind of angular, spur-like process, ridge, or buttress, which opposes an effectual obstacle to the passage of the contents of the upper portion of the bowel into the lower, which, in consequence, soon becomes empty and collapsed. As the patient has no control over his feces, they have an incessant tendency to escape, thus not only irritating and annoying him, but, what is worse, rendering him an object of disgust alike to himself and to all around. Moreover, he ordinarily suffers from prolapse of the mucous membrane of the gut, more especially of the superior extremity, and, if the opening happens to be situated high up in the canal, there is danger that his general health may become seriously affected from the want of

proper nourishment, in consequence of the premature escape of ingesta. Flatulence, pain, and indigestion are also common attendants upon intestinal fistule. It is proper to add that the ridge between the two cylinders is usually much less distinct when the accident supervenes upon a wound of the bowel, or a stercoraceous abscess, than when it is caused by mortification.

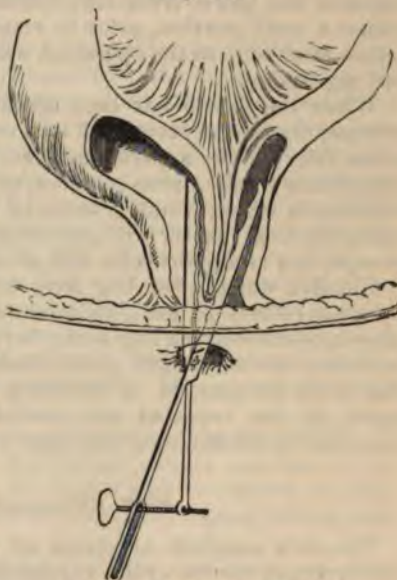
The opening in the wall of the abdomen, in which the ends of the bowel lie, is of variable diameter, shape, and depth, and is encircled by thick, irregular edges, generally more or less everted, or everted at one point and inverted at another. The surface immediately around, from the constant contact of fecal matter, bile, and mucus, is usually red, inflamed, chapped, or ulcerated, and so tender as to cause considerable suffering. At the bottom of the opening the two extremities of the bowel are closely embraced by a kind of membranous pouch, technically termed the infundibulum or funnel, of a firm, dense structure, from one to two lines in thickness, and formed by a prolongation of the proper hernial sac.

The *treatment* of intestinal fistule, occasioned by strangulated hernia, naturally divides itself into palliative and radical. The first consists in promoting the comfort of the patient, by strict attention to cleanliness, preventing the too early escape of the ingesta, and combating such accidents or complications as are liable to arise during the progress of the disease. The use of a well-adjusted truss, furnished with a broad pad to maintain equable pressure upon the parts, will not only afford great comfort, but may occasionally, especially if the spur-like process between the two cylinders is not too large or prominent, even effect a radical cure. When the case is irremediable, or unusually troublesome, a receptacle, made of gutta-percha lined with silver, must be worn, the vessel being frequently emptied and cleaned.

The radical cure may be attempted in one of two ways; either by means of the seton, as originally suggested by Physick and Schmalkalken, or with the enterotome, as practised by Dupuytren. The object of both is to destroy the spur-like process between the two intestinal cylinders, so as to reëstablish the natural route of the feces, and, when this is accomplished, the closure and cicatrization of the abnormal opening soon follow. The seton, which is best adapted to the milder forms of the affection, may consist of a piece of narrow braid or a stout gum-elastic thread, introduced with a short, curved needle, mounted upon a handle. It should be carried to a considerable height, in through one tube and out at the other, and be retained for several weeks, or until there is reason to believe that there is firm union between the two cylinders, when all that portion of the septum lying below the foreign body is cut away.

The enterotome consists of two serrated blades, a male and a female, about six inches in length, united by a movable pivot, and brought together by a screw passed through the ends of the handles. Fig. 490 exhibits the application of the instrument to the spur-like process formed by the junction of the two cylinders, one blade being inserted into the upper, and the other into the lower. Great care must be taken that the pressure in the first instance is not too firm, otherwise very serious suffering, if not death, may result. The proper plan is to tighten it gradually from day to day, until it has cut its way effectually through the septum. If, notwithstanding this, the patient experience much pain, free use should be made of anodynes, strict watch being kept all the while upon the peritoneum. Moreover, it will always be well, before commencing such an operation, to subject the patient to a certain degree of preparatory treatment, in order that he may be the better able to bear up under its effects. The instrument may usually be taken off in from six to eight days.

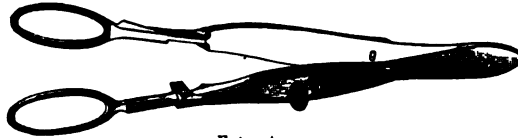
Fig. 490.



Dupuytren's Enterotome Applied.

The adjoining cut, fig. 491, exhibits an enterotome which I devised many years ago, while treating a case of artificial anus consequent upon a wound of the small

Fig. 491.



Enterotome.

bowel. It fulfilled the indication most admirably. It is much lighter and smaller than that of Dupuytren, while the pressure which it is capable of exerting is very great. It consists of two blades, brought together by a strong slide, and terminating each in a ring deeply notched on the inner surface.

Of 41 cases of this operation, in the hands of Dupuytren and other surgeons, 38 survived, and 3 died; one from peritonitis, one from indigestion, and one from fecal effusion. Of the former, 29 were radically cured in from two to six months, but the rest retained, in spite of all that could be done, fistulous openings, which compelled them constantly to wear a compress and bandage, to prevent the escape of air, mucus, bile, and even feces. Three-fourths of the cases had been caused by gangrene from strangulated hernia, and the remainder by penetrating wounds, attended with more or less loss of substance of the tube.

An intestinal fistule, caused by a wound of the bowel, is always extremely difficult to cure, owing to the small size, or entire absence, of the intervening spur not admitting of the ready application of the seton or enterotome. In an intractable case of this kind under my charge, some years ago, I was strongly tempted to liberate the bowel from its attachments, and either to sew up the opening, or to excise a small portion, prior to restoring it to the abdomen. The patient's indisposition to submit to the operation was the only thing that prevented me from carrying out my design.

When the fistule has been occasioned by ulceration of the bowel, or by a stercoraceous abscess, especially if it is connected with the cæcum or colon, great benefit, often followed by a permanent cure, will be derived from a rigid and protracted observance of the prone position, as originally suggested by Sir B. C. Brodie; as the opening in many, if not in most, of these cases exists at the posterior surface of the tube, the fecal matter will gradually, under the influence of this treatment, cease to escape, and an opportunity will thus be afforded the fistule to close.

Finally, when, after the feces have resumed their natural route, the external opening refuses to heal, an attempt may be made to effect its closure by a dermo-plastic operation, the flap being borrowed from the neighboring parts. In general, however, the effort will prove abortive, owing to the difficulty of preserving the flap from the contact of intestinal matter. Instances of cure, in these obstinate cases, by the repeated and careful application of the actual cautery, have been reported by Dieffenbach and others.

SECT. XVII.—AFFECTIONS OF THE UMBILICUS.

The only surgical affections of the umbilicus are papillary tumors, ulceration, hemorrhage, serous cysts, carcinoma, fistules, and hernia, the latter of which has already been described.

1. *Ulceration* of the navel is almost peculiar to early infancy, and is usually occasioned by neglect of cleanliness, or rude traction of the cord with a view of expediting its separation. Varying in degree from the merest excoriation to a deep spreading sore, it is always attended with inflammation of the adjacent parts, pain, tenderness, discoloration, and a thin, ichorous, acrid, and offensive discharge. The disease, although in general readily amenable to treatment, is sometimes exceedingly obstinate and rebellious, lasting for many years, now receding and almost entirely disappearing, and then again breaking out afresh, and proceeding with all its former energy. Occasionally an ulcer of this kind is the seat of a periodical hemorrhage, vicarious of the menses; and cases occur in which it is evidently of an eczematous nature, influenced in its origin and march by a strumous condition of the system.

The treatment of this disease will be greatly promoted, in most cases, by an occasional laxative, in union with an antacid. When the patient is pale and debilitated, the use of tonics will be necessary. The best topical remedies are mild

astringent lotions, such as solutions of zinc, lead, or copper, either alone or combined with tannic acid, Turner's cerate, or the dilute ointment of the nitrate of mercury. Dusting the surface of the ulcer with calomel, or covering it with dry lint, sometimes answers better than anything else. In all cases the greatest attention should be paid to cleanliness. When the sore is prevented from healing by overhanging integument, hardly anything short of the removal of the redundant structure will suffice, inasmuch as it serves to retain the secretions, and tends to rub and irritate the raw surface. When the affection extends into adult life, a mild mercurial course may be required.

2. *Hemorrhage* of the navel is sometimes met with either as a mere oozing or as an actual flow, generally about the time of the detachment of the cord, in delicate, sickly infants. If not speedily arrested, it may terminate fatally. The most effectual local remedy is the twisted suture. In the milder cases the object may sometimes be attained by the use of subsulphate of iron, aided by the compress and bandage. Caustic and ordinary styptic applications are generally hurtful. Iron, quinine, and brandy are the most suitable internal means.

Dr. Francis Minot, of Boston, has published an analysis of 46 cases of idiopathic hemorrhage of the umbilicus in new-born children, of which 39, or more than 84 per cent., were fatal, at periods varying from six hours to six weeks from the commencement of the attack. A majority of the infants were males, and nearly one half of them had jaundice. The history of the cases would serve to show that some of the children had been affected with the hemorrhagic diathesis. Of the 79 cases of this diathesis collected by Dr. Smith, of New York, other children of the same parents had perished in a similar manner in 26. Of 4 cases of fatal umbilical hemorrhage in my own practice three were preceded by jaundice and followed by petechiæ in different parts of the body.

3. The *papillary tumor* of the umbilicus is either congenital or comes on soon after birth, and is easily recognized by its florid, violaceous, or purple color, by its soft consistence, and by its rounded or conical shape. Its volume ranges from a cherry to that of a small fig, its base being at one time narrow, at another broad or expanded. It generally protrudes from the centre of the navel, although occasionally it is deeply buried at its bottom, with very little or no discharge, and without any appearance of ulceration or of inflammation in the surrounding parts. When rudely touched or irritated, it is liable to bleed. Occasionally there is an aperture at its summit, admitting of the passage of a fine probe, but of no escape of fluid. I recently saw a lady, forty-seven years old, who has had a tumor of this kind from birth. It first became sore during one of her pregnancies, and has continued to trouble her more or less ever since. It is about the volume of a strawberry, of a florid color, tuberculated on the surface, and the constant seat of a thin, fetid discharge, occasionally attended with a good deal of pure blood. It is sometimes quite painful, and now and then it is covered with a scab.

Removal is effected with chromic acid, applied once every other day; aided, if necessary, by the ligature, especially when the morbid growth is adherent by a narrow pedicle. When the reverse is the case, the tumor may be shaved off with the knife, repullulation being prevented by nitrate of silver, astringent lotions, and other suitable remedies.

4. A *cyst* containing water is occasionally met with at the umbilicus, and may acquire a considerable bulk. The tumor is soft, elastic, and fluctuating, free from pain, and slightly translucent. Its seat is apparently in the subperitoneal cellular tissue. The only disease with which it is liable to be confounded is umbilical hernia, but from this it may always be readily distinguished by its history, by its consistence, and by its fixedness, or our inability to push it into the abdominal cavity. In cases of doubt recourse is had to the exploring needle. The proper remedy is evacuation of the contents of the cyst, and the injection of tincture of iodine, as in the operation for the cure of hydrocele.

5. A tumor, probably the result of an irreducible *omental* hernia, occasionally forms at the umbilicus. In a case, apparently, of this kind which I recently saw in a young woman, a patient of Dr. William H. Pancoast, a rounded tumor, the size of a small orange, occupied the umbilicus, forming a hard, firm, inelastic mass, extending deeply into the abdominal wall, and connected, if one might judge by its feel, with a well-marked pedicle. The tumor had been originally observed about

a year before, and had latterly become somewhat red and tender on the surface, probably from the friction of the clothes.

6. The existence of *carcinoma* of the navel is extremely uncommon. The principal form in which it is observed is epithelioma, commencing as a small, indurated growth in the cicatricial tissue, from which it gradually extends, on the one hand, to the subcutaneous cellular substance, and, on the other, by means of the fibrous structures of the umbilicus, to the peritoneum. The tumor, which is nearly always very tardy in its progress, and which is met with chiefly in old subjects, is of great hardness, and the seat of sharp, lancinating pains; circumstances by which it may always be readily distinguished from other diseases. The skin is of a purple or violaceous color, and finally yields to ulceration, followed by a thin, ichorous, fetid discharge. The growth would seem, at first sight, to be superficial, but a more thorough exploration soon shows that it extends towards the abdominal cavity, one portion occupying the subcutaneous cellular tissue, and the other the subperitoneal, the shape of the mass resembling that of a shirt-stud, the constricted part corresponding with the navel. The treatment is limited to palliation, excision being improper, as it could not, owing to the peculiar arrangement of the tumor, be effected without the risk of peritonitis.

A case of encephaloid tumor of the umbilicus, circumscribed, well-defined, and about the volume of a large almond, has been observed by Dr. H. R. Storer, of Boston, in a woman, forty years of age. It exhibited during life all the features of an ordinary umbilical hernia.

7. Stercoraceous, urinary, and other *fistules* are sometimes met with at the umbilicus, but their occurrence, besides presenting nothing peculiar, is so uncommon as not to require any special notice. In a case of congenital intestinal fistule in a child seven days old, reported by Dr. A. S. Mayo, the cord had separated as usual, except that it had left an ulcerated surface, permitting the escape of flatus and fecal matter, more or less of which was also discharged by the anus. Nitrate of silver was freely applied, but the opening was not effectually closed until after the ligation of the stump of the cord.

In the *vesico-urachal fistule*, the urachus, which connects the summit of the bladder to the anterior wall of the abdomen, remains pervious, and thus allows the urine to escape at the umbilicus. The affection is nearly always congenital. The orifice of the fistule is indicated by a soft, reddish papilla, and, in general, readily admits of the introduction of a probe into the bladder. A case has been related in which such a passage was the seat of a ring-shaped calculus, formed around a hair. When the fistule proves troublesome a cure may usually be easily effected by paring the edges of its orifice, and approximating them with the harelip suture. Irritating the track with a probe dipped into a strong solution of nitrate of silver, nitrate of mercury, or chloride of zinc is sometimes followed by obliterative inflammation.

SECT. XVIII.—GENERAL DIAGNOSIS OF ABDOMINAL AFFECTIONS.

There are few surgeons, however skilful or experienced, who are not at times sadly perplexed in regard to the diagnosis of abdominal affections. These affections are not only of frequent occurrence, but greatly diversified in their character, and it is, therefore, of paramount importance that they should be accurately distinguished from each other. Several of them, indeed, sometimes coexist, thus not a little augmenting the embarrassment. Moreover, serious difficulty occasionally arises in determining whether the disease is seated in the parietes or in the cavity of the abdomen.

The surgical affections of the abdomen may, diagnostically viewed, be divided into two distinct classes: 1. The acute; and 2, the chronic. The former consist principally of abscesses, hernia, peritonitis, and retention of urine; the latter, of different morbid growths, enlargements, and effusions, together with certain pulsations closely simulating those occasioned by aneurism.

In all explorations of this kind the bowels should be thoroughly evacuated as a preliminary measure, and the surgeon should rapidly recall to mind the different regions of the abdomen with their respective contents. The patient should lie upon his back, or alternately upon his back and side, the muscles of the abdomen should be fully relaxed by elevating the shoulders and thighs, and all the manipulations—palpation and percussion—should be performed with the utmost gentleness, other-

wise they will be sure to occasion suffering, and so mar the result. The patient's mind should be diverted as much as possible, and no mistaken notions of delicacy should be permitted to interfere with the object of the exploration. If one examination does not suffice, another should be instituted, and thus the investigation should be continued until the diagnosis of the case has been satisfactorily determined. Sometimes chloroform may advantageously be exhibited, especially when there is extraordinary rigidity of the abdominal muscles.

Abscesses of the abdomen are for the most part of a phlegmonous nature, and are attended by the ordinary signs of such affections. They may be developed just beneath the surface, among the muscles, or immediately exterior to the peritoneum. Sometimes they are stercoraceous, hepatic, splenic, ovarian, or pelvic. Rigors always occur when the matter is deep-seated, or slow in finding an outlet, followed by hectic irritation and rapid emaciation. An abscess in the epigastrium and in the left side of the liver may receive a direct impulse from the aorta, and thus simulate aneurism. The stercoraceous abscess is most common in the groin and in the right iliac region; in the former, as a consequence of strangulated hernia, in the latter, of disease of the cæcum and vermiform appendix.

A psoas abscess, if unusually large, may project forward into the abdomen, in such a manner as to be easily felt through its walls, and thus occasion doubt as to whether the disease is an accumulation of pus, a mass of lymphatic glands, or an encephaloid tumor. The best guides to a correct decision are the history of the case, and a careful examination of the parts.

Hernia is most frequent in the groin, at the upper and inner part of the thigh, and at the umbilicus. If reducible, it will be found to be soft and gaseous, or partly soft and partly hard, as when it contains omentum, to receive an impulse on coughing, and to return with a gurgling noise. When strangulated, the tumor is tender and painful, or soon becomes so, the bowels are constipated, colicky pains are experienced, and at length stercoraceous vomiting ensues. Reduction is attended with more or less difficulty. Inguinal hernia is sometimes closely simulated by an undescended testicle, suddenly taking on inflammation, and a similar effect may be produced here, as well as in the thigh, by a diseased lymphatic gland. Occasionally these affections coexist. Whenever symptoms of strangulation occur, the judicious surgeon will not fail to seek for hernia, intussusception of the bowel, or visceral disease. Finally, hernia is sometimes simulated by psoas abscess, pointing either above or below Poupart's ligament.

Acute *peritonitis*, whether the result of external injury, strangulated hernia, fecal extravasation, cold, or tuberculosis, is characterized by excessive tenderness on pressure of the abdomen, retraction of the thighs, collapse of the features, tympanites, gastric irritability, and a small, hard, wiry, frequent pulse.

A distended *bladder*, from retained urine, might be mistaken for ascites or ovarian dropsy, but such errors can only happen in the hands of the most ignorant and careless observer. In general, the history alone of the case is quite sufficient to establish its true character.

Distention of the abdomen may be produced by fluid in the peritoneal cavity, gas in the intestinal tube, and urine in the bladder. In the first case, the collection generally occurs slowly, and is nearly always dependent upon organic disease of the heart, liver, spleen, peritoneum, or large vessels. Its presence is indicated by dullness on percussion, by fluctuation, and by the gravitation of the fluid to the lower part of the abdomen during the erect, and to the posterior and lateral aspects of the cavity during the recumbent, posture. The existence of gas, meteorism, or tympanites, is declared by a hollow, drum-like sound on percussion, generally perceptible over the entire abdomen, and by the unalterable condition of the tumor during change of posture. The tympanites is sometimes partial. A rapid accumulation of gas in the peritoneal cavity after injury of the abdomen may usually be regarded as a sign of a wound of the intestine. Great and rapid distention occasionally occurs from retention of urine. The history of the case, the median position of the tumor, with its gradual development from below upwards, and the inability to pass water, followed at length by incontinence, will, in general, suffice to point out the true nature of the affection.

Of the *tumors* which are liable to occur in the abdomen, some are fixed, others movable or floating. They may, moreover, be of new growth, or they may consist simply of enlargements of some of the viscera, as the spleen, liver, omentum, or

ovary. Hence, to refer them to their proper category is not always by any means an easy matter.

The most common of the fixed tumors of the abdomen are the encephaloid and the colloid, which sometimes completely fill its cavity, running in among the viscera, and producing one confused mass of disease, with enormous distention. The liver, mesenteric glands, uterus, and ovary are also capable of prodigious enlargement, especially the latter, the weight of which sometimes nearly equals that of the body.

Floating tumors of the abdomen are, for the most part, connected either with the omentum, the spleen, or the ovary; more rarely with the liver. As the name implies, they shift their locality with the position of the patient, rolling about from side to side, being here at one time, and there at another. This is especially true of omental tumors, which often slip about in the most perplexing manner. Ovarian tumors are almost always movable in their earlier stages; their situation is, at first, lateral and pelvic, but by degrees they ascend into the abdomen, and assume a median position, so as to render it difficult, if not impossible, to determine on which side they originated. A hydatid, attached to the liver, an enlarged spleen, and a dislocated kidney may float about very much as an omental or ovarian tumor.

Aneurism of the abdomen is liable to be simulated by numerous affections, often existing under very dissimilar conditions. Of these affections the principal are tumors of the stomach, liver, pancreas, mesentery, and omentum, impacted fecal matter, masses of worms, and gaseous accumulations, overlying the ventral arteries, especially the aorta, and thus receiving their pulsations.

Aneurism of the abdominal aorta is much more frequent in men than in women, and seldom occurs before the age of fifty. The tumor is fixed, and easily recognized in the flaccid state of the bowels. The murmur, thrill, and impulse are steady and persistent, not changeable and occasional, as in mere nervous or inflammatory affections of the aorta. In aneurism of the superior mesenteric artery the tumor is generally more or less movable.

Tumors connected with the stomach and omentum are commonly of a floating character, and readily pushed from side to side; those of the pancreas and mesentery, on the contrary, are nearly always fixed, and remarkably hard, firm, and unyielding, especially when they are of a carcinomatous nature. In the latter case, the enlargement is gradual, and usually attended with great gastric irritability. Fecal and gaseous accumulations generally promptly disappear under the use of a brisk purgative. An enlarged liver sometimes receives the pulsations of the aorta, and a similar phenomenon has been witnessed in a distended bladder. Extraordinary fullness in the lumbar region is denotive of hypertrophy, dropsy, or encephaloid of the kidney, or of carcinomatous disease of the suprarenal capsule. If the affection is associated with excessive pain and rigors, the existence of abscess may be suspected. In chronic enlargement of the spleen, the tumor is seated in the left side, from which it may extend across to the umbilicus, and even down into the hypogastrium; it is very hard and firm, almost immovable, and more or less sharp along its dextral margin. A distended gall-bladder may form a large swelling, projecting over towards the umbilicus, pyriform, elastic, fluctuating, and varying with the position of the body. Jaundice is generally a prominent attendant upon the disease.

The *stomach* is occasionally displaced by a mass of solid substance in its interior, as in the remarkable case recorded by Mr. Marshall, in which the pyloric extremity of the organ was dragged down into the left inguinal region by a collection of pins, swallowed from time to time by the patient. The tumor thus formed was of the size and shape of the placenta; it weighed nine ounces, and was distinctly traceable during life.

The *phantom tumor* of the abdomen, as it has been called, on account of its deceptive character, has sometimes led to most serious errors of diagnosis. Thus, Dr. Bright mentions a case in which the surgeon was so thoroughly convinced of the existence of a cyst that he was induced to perform ovariectomy, when, as was afterwards proved, the fallacious appearance was solely dependent upon a tympanitic condition of the abdomen. A similar mistake was committed by Lizars, of Edinburgh. Gooch refers to a case in which, the abdomen being laid open, the enlargement was found to be entirely due to flatulence and fat. Dieffenbach, in 1828, was induced, at the instance of Heim, to perform the Cæsarian operation under the belief that the patient was affected with extra-uterine pregnancy; but there was no fœtus, no tumor, or even any visceral enlargement. The phantom tumor is most

common on the right side, in young, nervous, hysterical females. The causes which give rise to it are, principally, solid fecal accumulations, irregular contractions of the bowel at two points, with intervening distention with flatus or fluid matter, and spasmodic rigidity of the muscles of the abdomen, especially the straight.

The best mode of detecting the true nature of this singular affection is to make firm pressure with the hand upon the abdomen as the patient lies upon her back with the knees drawn up and the head and shoulders thoroughly elevated. Success will be more likely to follow if the attention be diverted by keeping up a conversation unconnected with the character of the complaint. If these expedients fail, recourse should be had to chloroform, under the influence of which the tension and largeness almost completely disappear, recurring, however, as soon as the effects of the anæsthesia have passed off.

Perplexity may be experienced in determining whether a tumor is situated in the intestines or in the cavity of the abdomen. The former are occasionally the seat of mucous, encysted, and encephaloid formations, and such is the obscurity attending their development as to render it often extremely difficult to establish their true site and character.

A gravid uterus has sometimes been mistaken for ascites, or ovarian dropsy; an operation has been performed, no fluid has escaped, and the true nature of the case is only determined by the delivery of the child. On the other hand, numerous examples have occurred in which pregnant females were tapped under the supposition that they labored under ascites.

Symptoms of a very perplexing character may be induced by abnormal pulsations of the aorta. The occurrence, although most common in nervous, anemic, or hysterical females, is also occasionally witnessed in men, and is usually associated with inordinate action of the carotid arteries. Its exciting cause is either an impoverished condition of the blood, or neuralgia of the ventral aorta, or of this vessel and the solar plexus. It may likewise depend upon inflammation of the aorta. The pulsations are frequently so violent as to admit of being both seen and felt. The best way to escape error is to examine the abdomen after thorough evacuation of the bowels, when it will generally be easy to trace the outline of the affected vessel, and thus remove all doubt respecting the real character of the complaint.

Finally, grave error has sometimes arisen from the existence of a *movable kidney*. An instance is recorded in the London Lancet for March, 1865, in which an organ of this kind, affected with malignant disease, was supposed to be an ovarian tumor, a mistake which was not discovered until after an operation had been commenced for its extirpation. When a kidney is in this displaced condition, it may generally be readily pushed about from one point to another, and form a tumor of a dense, firm consistence, and of unvarying size; circumstances which, added to the fact that the corresponding loin is always unnaturally flat, and that it affords a distinct tympanic sound on percussion, are sufficiently denotive of the true character of the case.

CHAPTER XVII.

DISEASES AND INJURIES OF THE URINARY ORGANS.

SECT. I.—AFFECTIONS OF THE KIDNEYS AND URETERS.

THE kidneys are liable to wounds, lacerations, contusions, fistules, inflammation, abscesses, calculi, dropsy, hydatids, worms, encephaloid, and hemorrhage; affections of more or less surgical interest.

1. *Wounds*.—Wounds of the kidneys, whether incised, lacerated, or gunshot, generally speedily terminate fatally, either from shock, or shock and hemorrhage, from inflammation of their proper substance, or from peritonitis, the latter event being sure to happen whenever there is the slightest escape of urine into the abdominal cavity. Death occasionally occurs at a somewhat remote period, as a few weeks or months after the infliction of the injury, from pyæmia, secondary hemorrhage, hectic irrita-

tion, or purulent infiltration in the cellular tissue around the affected organ. Wounds of the pelvis and great vessels of the kidneys are particularly fraught with danger, inasmuch as the former is almost invariably followed by fatal extravasation of urine, and the latter by exhausting hemorrhage. The prognosis in wounds of the cortical substance is more favorable than in wounds of the tubular, and in wounds of the posterior surface of the kidney than of the anterior, or where it is covered by peritoneum.

The existence of a wound of the kidney is denoted by the presence of blood in the urine, a frequent desire to micturate, pain and sense of weight in the lumbar region, and retraction of the testicles, accompanied, if the injury is at all severe, by excessive prostration, nausea and vomiting, deadly pallor of the countenance, clammy perspiration, and coldness of the extremities. These symptoms, however, may all be fallacious; but if, superadded to them, there is an escape of urine at the wound, no doubt can remain respecting the true character of the lesion. Useful information may sometimes be obtained from an examination of the situation and direction of the wound.

In the treatment of these lesions the first thing to be done is to remove any foreign matter that may be present, and the next to limit, as much as possible, the resulting inflammation. All officious probing is, of course, avoided, nor is the opening dilated, unless it is imperatively necessary. The posture of the patient should be such as to render the wound the most depending part of the body, in order to facilitate drainage and the ready passage of the urine. If plethora exist, blood should be taken freely from the arm and by leeches from the loin and abdomen, the bowels evacuated by gentle cathartics, and the heart's action subdued by *veratrum viride* or aconite, in combination with morphia. Diuretics must be rigidly abstained from, and thirst must be allayed with ice. The use of the catheter will be required if the bladder is filled with clotted blood, obstructing the flow of urine. If the renal lesion is complicated with peritoneal, nothing should be permitted to pass the bowels for many days. Urinary infiltration, erysipelas, and abscesses consequent upon the injury must be treated upon general principles.

2. *Lacerations*.—Accidents of this kind may be produced by falls, blows, or kicks, and are generally associated with serious injury of the abdominal viscera, with fracture of the ribs and pelvic bones, and with contusion of the skin and muscles, although occasionally there is no mark whatever of external violence, not even the slightest ecchymosis. The rent may be confined to the cortical substance, or it may extend through this into the tubular, or even into the pelvis and calyces; its direction is usually transverse or longitudinal. Sometimes the organ is literally split in two.

The accident is commonly attended with considerable effusion of blood into the surrounding cellular tissue, and sometimes, also, into the peritoneal cavity. The symptoms resemble, in general terms, those of a wound of the kidney; the urine is bloody, and the distress in the lumbar region excessive. The period at which death occurs varies from a few minutes to several hours, days, or weeks. The injury, however, is not always fatal. In favorable cases the gap is gradually repaired, and the patient recovers. The treatment must be chiefly by leeches, blisters, fomentations, rest, and anodynes.

3. *Contusions*.—A mere contusion of the kidney sometimes proves to be a very serious accident, leading to violent, if not fatal, inflammation of its substance, attended with great constitutional disturbance. The urine is generally bloody, the lumbar region is more or less profoundly ecchymosed, and the patient is unable to move about in bed. The accident is often followed by peritonitis, and by extensive abscesses in the cellular tissue around the injured organ. A very slight blow upon the loin is capable of causing death when the kidney contains a ragged calculus, the sharp points puncturing the bloodvessels. The treatment must be conducted upon the same principles as in wounds and lacerations of this organ.

4. *Fistules*.—Wounds, lacerations, contusions, and abscesses of the kidney are occasionally succeeded by a renal fistule, occupying, for the most part, the lumbar region, but sometimes the groin or abdomen. The affection, which is characterized by a constant discharge of pus and fetid urine, always evinces a peculiar obstinacy, although a number of cases have been reported in which it disappeared spontaneously. Dr. Hermann Demme, of Bern, states that, during the Italian campaign in 1859, he saw not less than three instances of renal fistule, consequent upon gun-

shot injury, recover in this way. Efforts at a cure should be aided by attention to cleanliness, stimulating injections, and cauterization with nitrate of silver.

5. *Inflammation*.—Inflammation of the kidney may be acute or chronic, the latter being by far the more frequent of the two. As an idiopathic affection it is extremely rare. The most common exciting causes are external injury, the presence of renal calculi, irritating diuretics, stricture of the urethra, enlargement of the prostate gland, and chronic disease of the bladder. In some cases it is provoked by the gouty or rheumatic diathesis. The inflammation may be limited to the proper renal tissue, or it may at the same time involve the pelvis and calyces, thus constituting what is termed *pyelitis*.

The most prominent symptoms of *acute nephritis* are sharp, spasmodic, or dull, heavy, deep-seated, aching pains in the loins, increased by pressure and motion, and extending along the spermatic cord, up the back, down the thigh, and into the pelvis; retraction of the testicles; scanty, high-colored urine; irritability of the bladder, with a frequent desire to micturate; pyrexia; great thirst; restlessness; nausea, vomiting, and, in most cases, constipation of the bowels. If the urine be examined with the microscope, blood, pus, and renal casts may generally be detected. If permitted to progress, the disease either passes into suppuration, or it assumes the chronic form.

The treatment consists, mainly, in perfect quietude of mind and body, general and local bleeding, fomentations of the loins, mercurial purgatives with morphia, antimony, and varatrum viride, and cooling drinks. If the attack prove obstinate, a large blister may be applied to the affected region. When the disease is manifestly of a gouty or rheumatic nature, the most suitable remedies will be colchicum and Dover's powder, with alkaline drinks.

Chronic nephritis is generally dependent upon organic disease of the urethra, bladder, or prostate gland, attended with permanent obstruction to the free evacuation of the urine. In consequence of the obstacle thus occasioned, the ureters are habitually distended with urine, and are eventually transformed into subsidiary reservoirs, in which the fluid accumulates in such a manner as to produce serious pressure upon the renal tissues, and ultimately their partial, if not complete, destruction.

The suffering in chronic nephritis is usually much milder than in the acute form. The pain is less severe, and seldom extends to any distance among the neighboring structures; there is no retraction of the testicles; the bladder is irritable and impatient of its contents; and the general health, perhaps long impaired, gradually declines, the patient losing flesh, sleep, appetite, and strength. By and by hectic fever sets in, attended with frequent fits of headache, drowsiness, and vomiting, and life is finally worn out by sheer exhaustion. Sometimes death is caused by suppression of urine, preceded and accompanied by coma and convulsions; at other times, by the sudden supervention of acute nephritis, an event generally announced by rigors, violent fever, and delirium, with great increase of the local distress.

The urine in chronic nephritis is commonly alkaline, turbid, and loaded with calcareous matter and ammoniaco-magnesian phosphates; not unfrequently it is albuminous, tinged with blood, or mixed with pus, flakes of lymph, and renal casts.

The kidney after death is found to be variously altered; generally softened and disorganized, atrophied or enlarged, and converted into cysts, or into a single pouch destitute of secreting tissue. The capsule is usually opaque, thickened, and easily separable, but firmly adherent to the fat and areolar substance of the loin.

The treatment of chronic nephritis is commonly unsatisfactory. In all cases an attempt should be made to ascertain, as soon as practicable, the nature of the exciting cause, the removal of which will often, of itself, be sufficient to cure the disease. Tonics and alterants, with a regulation of the diet and bowels, will, generally, prove highly beneficial. Fatigue and sexual excitement should be avoided; opium will be required to allay pain and promote sleep; and the surface should be well protected with flannel. Many cases will be improved by the warm bath, by change of air, and by alkaline or acid preparations in combination with uva ursi, lupuline, or balsam of copaiba.

6. *Abscesses*.—Renal abscess may be occasioned by ordinary inflammation, tuberculosis, external injury, or the presence of a renal calculus. Sometimes it is produced by the irritation consequent upon disease of the bladder, enlargement of the prostate gland, or stricture of the urethra. The abscess may be seated on the outer surface

of the organ, immediately beneath its fibrous envelop, in its proper substance, or in the pelvis and calyces, especially when it depends upon obstruction of the ureter. The disease may be acute or chronic. In chronic abscess, the kidney is sometimes completely destroyed, the parenchymatous structure being replaced by a thick, laminated, multilocular sac, intersected by hard, fibrous bands.

Abscess of the kidney is sometimes dependent upon disease of the spinal marrow, or upon the nerves which are detached from it. The subjects are usually affected with paralysis of the lower half of the body, accompanied with pain and tenderness of the sacrolumbar region, irritability of the bladder, and a phosphatic condition of the urine. The kidney sometimes suffers from abscesses in pyemia, after injury of the head, compound fractures, dislocations, smallpox, carbuncles, lithotomy, lithotripsy, and stricture of the urethra. In 2161 autopsies performed at St. George's Hospital, London, Dr. Chambers found metastatic abscesses in the kidneys in 12 cases, in the lungs in 106, and in the liver in 22.

When the pus collects around the kidney, in the cellulo-adipose substance of the loin, the abscess takes the name of *perinephritic*. Such an abscess may arise from the same causes as a renal abscess, as external injury, disease of the kidney, or the irritation of a renal calculus, and the quantity of matter thus formed is sometimes very great.

The matter contained in these abscesses may be perfectly homogeneous, thick, opaque, and yellowish, like healthy pus, or it may be intermixed with various kinds of foreign ingredients, as lymph, blood, urine, sabulous matter, renal casts, and even calculous concretions. Occasionally it is serous, or sero-purulent, lactescent, whitish, or greenish-white, thin or thick, viscid or curdy. In the scrofulous form of the disease it always exhibits the characters peculiar to an abscess of that nature. The pus, which varies in quantity from a few drachms to several quarts, may be entirely inodorous, or intensely fetid. In a preparation in my possession, taken from a man, twenty-six years of age, there were upwards of two gallons of thick, yellow pus. The kidney was converted into an immense sac, exceedingly vascular, about the thickness of the human skin, and studded internally with numerous calcareous deposits. The ureter was completely occluded, and the proper renal substance entirely destroyed. The disease, which had existed for several years, was attended with great pain and excessive emaciation.

The renal abscess generally opens into the pelvis of the kidney, its contents being thence discharged along with the urine. More rarely the matter finds its way to the external surface, into the cellulo-adipose tissue of the loin, or into the intestinal canal. It may also be evacuated into the peritoneal cavity; and cases have occurred in which it burst into the bronchial tubes, from which it was subsequently discharged by coughing.

The matter, instead of being evacuated, may remain in the kidney, and, parting with its more watery particles, be ultimately converted into a dry, putty-like substance, consisting of degenerated pus globules, intermixed with phosphate and carbonate of lime.

The symptoms of renal abscess do not differ essentially from those which attend suppuration in the other viscera. There is generally severe pain in the corresponding loin, extending down the spermatic cord, groin, thigh, and sacrum, the urine is high-colored and scanty, the patient finds it difficult, if not impossible, to walk and turn in bed, intense febrile disturbance is present, with gastric irritability, and, at length, violent rigors come on, preceded by throbbing pain, and followed by copious sweats. If the matter passes off by the urine, its characteristic appearances may always be readily detected in that fluid, and in most cases a distinct swelling, exquisitely tender on pressure, and gradually enlarging in size, may be perceived in the lumbar region, especially when the pus is pent up. When the disease is of a scrofulous nature the symptoms are generally more mild, and several months commonly elapse before the abscess acquires much bulk. When an acute renal abscess opens or points externally, the event is invariably preceded by an erysipelatous blush of the surface, and by an œdematous condition of the subcutaneous areolar tissue. In chronic or scrofulous renal abscess, instead of these phenomena, there is, on the contrary, in general merely a glossy appearance of the skin, along with more or less enlargement of the subjacent veins.

The diagnosis of renal abscess is usually readily determined by its peculiar symptoms, and by a careful study of the history of the case. The chief risk of error is

in the chronic or strumous form of the disease, which might, even in the hands of a cautious observer, be mistaken for an encephaloid tumor, a hygromatous cyst, or a psoas abscess. The presence of pus in the urine is of great significance in connection with a fluctuating tumor in the loin, although not positively decisive. Rigors are of frequent occurrence in the phlegmonous abscess, and are among the most valuable signs of the disease. A perinephritic abscess cannot, in general, be distinguished from an abscess in the renal substance.

The prognosis is commonly unfavorable; a case may, it is true, occasionally recover, but generally the disease terminates fatally, whatever may be its nature. When the abscess opens externally, the patient may live for some time with a renal fistule.

The treatment of this affection must, at first, be strictly antiphlogistic, and afterwards supporting. When the matter is tending externally, its approach to the surface may often be expedited by the application of a blister. As soon as fluctuation becomes apparent, or even before if there be excessive local and constitutional suffering, a free incision should be made, to afford full vent to the pent-up fluid.

7. *Calculi*.—Calculi of the kidney may be developed either in the parenchyma of the organ, or in the calyces, infundibules, or pelvis, a drop of blood or a portion of inspissated mucus generally serving as their nucleus. Their formation often begins at an early period of life, either as the result of external injury, disease of the spinal cord, or of a peculiar diathesis of the system; and they usually consist of the same chemical elements as calculi of the bladder.

The most common species of renal concretion is the uric, which is usually of a light brownish color, and of a spherical, oval, or conical shape, with a finely tuberculated surface. Next in point of frequency is the oxalic, of a dark complexion, and of an irregular, rounded figure, with a rough exterior, similar to that of a mulberry. The ammoniaco-magnesian calculus is uncommon in the kidney; it generally occurs in connection with one or the other of the preceding species, as an external layer, from a line to half an inch in thickness. The pure phosphatic concretion is also rare, and is met with chiefly as a consequence of injury of the spinal cord.

Dr. Scott Alison has reported a case of what he calls blood calculi of the kidney, in a man dead of phthisis. The concretions were of a black color, from the size of a coriander-seed to that of a small horse-bean, and were essentially composed of blood, of tolerably firm consistence.

The number of renal concretions ranges from a single one to as many as six, ten, or even a dozen. The oxalic calculus is generally solitary. Their volume is usually in an inverse ratio to their number. In shape, they are, for the most part, round or oval. A solitary renal concretion occasionally pretty accurately represents not only the general outline of the kidney, but also of the calyces and infundibules.

The effects which a concretion exercises upon the substance of the kidney are often most disastrous, especially when it is very bulky or has been long retained. Gradually the parenchymatous substance is absorbed, until, at length, perhaps, nothing remains but the fibrous envelop of the organ, converted into a thick, indurated sac, partially filled with pus, serum, or sero-purulent fluid. The corresponding ureter may be closed, as well as variously changed in structure, and serious morbid alterations are often met with, as a direct consequence of the renal, in the bladder and prostate gland.

Persons affected with renal calculus generally suffer more or less severely in the loin and pelvis, the pain, which is dull and aching—sometimes sharp, stabbing, boring, or neuralgic—radiating about in different directions—being liable to serious exacerbations from the slightest exposure, or irregularity of diet; the general health is habitually deranged; the stomach is teased with flatulence and indigestion; the bowels are costive; the system is extremely susceptible to atmospheric vicissitudes; the countenance is wan and sallow; and there is a frequent desire to void urine, which is usually materially altered in its physical and chemical properties. In many cases, pure blood is passed, especially after rough exercise. Ultimately hectic irritation ensues, and the patient dies from sheer exhaustion, an abscess having, perhaps, previously formed, and pointed in the loin, or discharged its contents along the ureter. Occasionally the immediate cause of death is suppression of urine, or shock from the sudden obstruction of the ureter by the foreign body.

The concretion, even if comparatively small, as when it does not exceed the volume of a pigeon's egg, or an almond, may sometimes be readily detected, especially in

lean subjects, after thorough evacuation of the bowels, by firmly grasping the lumbar region, immediately below the last rib, with the fingers of one hand resting upon the anterior border of the erector muscle of the spine, and making counter-pressure with the thumb, while the fingers of the other hand are passed up and down over the intermediate surface in front. In this way it is very difficult for any hard substance, irregularity of surface, or distention from fluid, to escape discovery. The patient, during the examination, should lie on his back, with the limbs well flexed, to relax the abdominal muscles; chloroform being given if there is much pain or nervous agitation.

The treatment in retained renal calculus is, in general, altogether palliative, consisting of the abstraction of blood by cups and leeches, the warm bath, and the administration of anodynes. Horseback exercise must be avoided, the diet carefully regulated, the bowels constantly kept in a soluble condition, and the skin well protected with flannel.

When the stone is large, and productive of incessant and severe suffering, *nephrotomy* has been recommended; but such a procedure could only be thought of when the concretion is of immense bulk, or when it has worked its way partially through the loin by ulceration. In such an event, it might easily be cut down upon, and removed, with a fair prospect of a tolerably good recovery. The operation, already recommended by Hippocrates, is said to have been successfully performed upon an Englishman, at Venice, by Marchetti, of Padua, in the seventeenth century. Professor Durham, of London, and Professor Gunn, of Chicago, have each reported a case of nephrotomy performed on account of the supposed presence of a renal calculus. Although no stone was found, both patients were temporarily relieved of the distressing pain and nausea under which they had so long labored.

Renal concretions often descend into the bladder. Their progress along the ureter is sometimes slow and painful; at other times, rapid and almost free from suffering. The amount of the local distress is often greatly influenced by the nature of the concretion, and by the degree of resistance offered by the ureter. A small, smooth calculus usually causes little inconvenience; while a large or rough one often occasions exquisite torture. The process of descent, which generally occupies from twelve to forty-eight hours, is characterized by excessive nausea and vomiting, great restlessness and jactitation, pain in the back, groin, and thigh, retraction of the testicles, numbness along the spermatic cord, a sense of constriction at the umbilicus, and tenderness of the hypogastrium, with coldness of the extremities, rigors, and a feeling of excessive prostration. The urine gradually accumulating behind the calculus, the ureter is slowly dilated, and the concretion at length reaches the bladder, from which it is either ejected, or it remains there until it is removed by operation. As soon as the passage is completed, the pain and sympathetic irritation subside, the patient frequently falling into a tranquil and refreshing sleep. The descent of the calculus may be expedited, and rendered less painful, by the abstraction of blood from the arm, the loins, or hypogastric region, by large doses of morphia, along with castor oil and turpentine, and by the hot bath, fomentations, and anodyne injections. The free use of chloroform, by inhalation, will also prove highly beneficial.

8. *Hydronephrosis or Renal Dropsy*.—Enormous quantities of urine, or urine and serum, occasionally collect in the kidney, from obstruction of the ureter, and the consequent conversion of the organ into a mere membranous pouch, sac, or shell, capable of holding many quarts of fluid, and constituting what is technically called hydronephrosis. The disease, although generally limited to one kidney, occasionally involves both organs, and, what is remarkable, the patient, in such an event, may live for years, and void daily the ordinary quantity of urine, notwithstanding the complete destruction of the tubular structure. Inflammation, renal calculi, displacements of the uterus, and the pressure of morbid growths, are the most common exciting causes of the malady, leading to occlusion of the ureter, followed by the gradual disorganization of the renal substance, and the conversion of the kidney into a membranous sac, either single or multilocular; commonly the former. Many cases have been recorded in which it was congenital, giving rise to great difficulty in parturition; but, in this event, the affection is usually due to cystoid dilatation of the Malpighian corpuscles and urinary tubules, from obliteration of their caliber. The ureter is often prodigiously enlarged, tortuous, and convoluted.

The diagnosis of renal dropsy is seldom difficult. The chronic march of the disease, the steady wasting of the flesh and strength, and the existence of a tumor,

fixed, soft, and fluctuating on pressure, in the iliac, or ilio-lumbar region, hardly admit of misinterpretation. As the enlargement progresses, it gradually extends over the abdomen, and encroaches more or less upon the contained viscera. The pressure exerted upon the diaphragm is sometimes so great as to cause serious embarrassment in respiration, especially during recumbency and after eating. The colon usually lies in front of the tumor, and emits a clear sound on percussion. The subcutaneous veins are often remarkably distended. Occasionally the sac suddenly gives way, followed by the escape, by the ureter, of the greater portion of its contents; and such an event always affords the best evidence of the true nature of the complaint. Whenever any doubt exists in regard to the diagnosis, the proper plan is to employ the exploring needle.

The period at which death occurs, when the disease is permitted to pursue its course undisturbed, varies from two to six, eight, or ten years. In the congenital form of hydronephrosis, life is usually destroyed much sooner.

The only chance for relief is tapping, experience having shown that the fluid is not amenable to absorption. In performing the operation, the trocar must be introduced at the posterior part of the tumor, beyond the range of the colon, which, as before stated, generally courses over its anterior surface, and might, therefore, be penetrated, if this precaution were disregarded. When the tumor is multilocular, as in fig. 492, from a preparation in my cabinet, it may be necessary to puncture it at several points.

9. *Hydatids*.—Hydatids of the kidney are extremely uncommon. Usually developed in the parenchymatous substance, or in the excretory passages of the organ, and sometimes lodged just beneath the capsule of the gland, they vary in size from a hempseed to that of an orange, and in number from one to several hundred. Men are more liable to them than women, and they have been met with at both extremes of life, although their favorite period of attack seems to be between the thirtieth and fortieth years. Of their causation, nothing definite is known. The older hydatids generally contain clusters of young ones, either loose or adherent to their inner surface. The outer cyst often possesses great firmness, and instances have been observed in which it was partially calcified, or incrustated with chalky matter. When very large or numerous, which, however, is rarely the case, these bodies may completely destroy the renal tissues, and so give rise to the same morbid states as a serous cyst or a chronic abscess. They may remain pent up in the situation where they are originally developed, or they may escape into the pelvis of the kidney, and be evacuated along with the urine. Occasionally, although very rarely, they make their way through the lumbar region into the intestines, or even into the lungs. In no instance on record have they discharged themselves into the peritoneal cavity.

The only positive-evidence of the existence of hydatids in the kidney is the presence of hooklets, laminated shreds, broken fragments, or milky detritus in the urine, detectable by the microscope. Sometimes entire vesicles, either alone or mixed with disintegrated ones, are discharged. All such appearances are, of course, perfectly diagnostic, especially when associated with a fixed tumor, of variable size and shape, in the loin, or in the ilio-lumbar region. When the acephalocysts are large or numerous, the tumor will not only be of considerable bulk, but it will be likely to fluctuate distinctly on pressure, and to yield the peculiar characteristic thrill, known as the hydatid fremitus, perceptible both by the ear and the touch. "In order to evoke these signs," says Dr. Robertson, "the fingers of the left hand should be laid upon the tumor, and tapped sharply with the fingers of the right. A thrill is then communicated to the overlaid fingers, which has been compared to the vibrations of a repeater watch held in the hand. A similar sensation is communicated to the ear when the stethoscope is applied and the tumor tapped with the fingers." The tumor varies in size from that of an orange to that of an adult's

Fig. 492.



Multilocular Cysts of the Kidney.

head, and, as it progresses, it gradually displaces the adjoining viscera. The colon generally lies in front of the tumor, but in some cases it runs along its inner or outer side.

The discharge of vesicles or disintegrated cysts takes place at irregular, and often at very distant, periods; at one time spontaneously and at another under the influence of external injury, as a blow, kick, or fall. A favorable termination of the disease is by no means uncommon, the hydatids gradually dying, and passing off by the ureter. The patient occasionally perishes from constitutional irritation.

The best remedy for destroying and dislodging these parasites is oil of turpentine in diuretic doses. Advantage has occasionally been derived from the use of nitrate of potassa and iodide of potassium. Attempts have been made to kill the hydatids with electricity, but without success. When the tumor points externally, the proper plan is to puncture it, and let out its contents, the trocar being introduced behind in such a manner as not to wound the peritoneum. The cyst may afterwards be injected with a weak solution of iodine, or washed out from time to time with permanganate of potassa, so as to excite obliterative inflammation.

10. *Parasites*.—The strongle, a slender, cylindrical worm, from two to six inches in length, and of a light grayish color, has occasionally been found in the pelvis and infundibules of the kidney. Sometimes it makes its way into the parenchymatous substance, causing suppuration, atrophy, and other mischief. The parasite causes much distress in the kidney, but affords no distinctive symptoms. When its presence is suspected, expulsion may be attempted with turpentine, cubebs, and balsam of copaiba.

11. *Encephaloid*.—Encephaloid of the kidney is liable to take place at all periods of life. Of 54 cases collected by Dr. Robertson, 19 occurred before the tenth year, and 35 between the ages of nineteen and seventy. The tumor often acquires an enormous bulk, especially in young subjects. In an instance recorded by Mr. Wells, a growth of this kind, removed from the body of a child only four years of age, weighed upwards of sixteen pounds. The disease is more frequent in males than in females, generally comes on without any assignable cause, and terminates fatally at a period varying from a few months to several years. In the cases analyzed by Robertson, the duration was much shorter in children than in adults, the average in 14 cases of the former being between seven and eight months. In 20 adults the mean duration was two years and a half. The general health is usually rapidly impaired, the body becomes emaciated, the strength declines, the limbs swell, and the countenance assumes that peculiar sallow appearance so expressive of the malignant nature of the disease.

Encephaloid of the kidney usually makes its appearance in small, whitish masses, which, increasing in volume and number, gradually coalesce, and at length transform the organ into a soft, pulpy mass, of a brain-like color and consistence. The tumor, in the advanced stage of the disease, is irregularly lobulated, the fibrous envelop loses its identity, and the pelvis and ureter are occluded by the carcinomatous substance. A section of the morbid growth occasionally presents a large clot, composed of loose, concentric layers, similar to those in a rapidly formed aneurism. Now and then large cavities, filled with bloody serum, either alone or mixed with softened carcinomatous matter, are contained in it, and serve to diversify its character.

The true nature of this disease is not always easily determined, inasmuch as it is liable to be confounded with various other affections, not only of the kidney itself but of the other pelvic and also of the abdominal viscera, as renal and hepatic cysts, hypertrophy of the spleen, omentum, and mesenteric glands, lumbar, stercoraceous and abdominal abscesses, accumulations of fecal matter in the colon, aneurism of the aorta, and tumors of the ovary, uterus, and Fallopian tube. On the right side an enlarged liver may complicate the disease and obscure the diagnosis.

The most reliable phenomena, diagnostically viewed, are, the existence of a fixed tumor in the flank, and the presence of blood or of blood and particles of carcinomatous matter in the urine. When these phenomena are associated, there can be no reasonable doubt as to the true nature and seat of the malady. Unfortunately, however, this is not always the case. In many instances, indeed, owing to the occlusion of the ureter, there is an absence both of hematuria and of carcinomatous material, especially in the more advanced stages of the complaint. The tumor, originally situated in the flank, between the crest of the ilium and the margin of

the ribs, gradually extends in different directions, pushing aside the different organs of the abdomen, and sometimes filling almost its entire cavity. Its surface is more or less lobulated, irregular in consistence, and remarkably tolerant of manipulation. An important feature of the tumor is its fixity, and consequent inability to shift its place or move about. The skin by which it is covered is often traversed by large veins, of a dark bluish color, but in other respects it is unchanged. The morbid mass early contracts adhesions to the surrounding parts, especially to the bowels; and the descending colon invariably lies immediately in front of it, immediately beneath the wall of the abdomen. Hence, while all the rest of the tumor furnishes a dull sound on percussion, that portion which corresponds with the colon is always more or less resonant. The absence of serious vesical disorder should not be overlooked, as it affords valuable negative information. The history of the case is also highly important. In two instances of this disease, one recorded by Langstaff and the other by Bristowe, distinct and persistent pulsation existed in the tumor.

The treatment of encephaloid of the kidney is of course entirely palliative. All that can be done is to relieve pain and to support the strength. The attendant hemorrhage is best controlled by acetate of lead and tannic acid in union with opium.

12. *Hemorrhage*.—Renal hemorrhage is usually caused by mechanical violence, as blows, contusions, or the presence of renal calculi; but it may also be produced by congestion of the kidneys, hematoid growths, parasites, or diseased conditions of the blood, such as attend scurvy, scarlatina, or typhoid fever. The amount of blood may be small, or so great as to be exhausting. Unless accompanied by marked disorder of the kidney, entire absence of vesical disease, or the presence of renal casts in the urine, along with small spherical particles of epithelium, such a hemorrhage can seldom be satisfactorily distinguished from hemorrhage of the ureters, bladder, prostate gland, or urethra.

The treatment must be regulated by the nature of the exciting cause. If plethora exist, bleeding by cups, leeches, or the lancet may be necessary, with active purgation, and the exhibition of acetate of lead and opium, or, what is better, tannic acid, in doses varying from five to ten grains, repeated every three or four hours. Alum sometimes answers a good purpose, as does also the tincture of ergot. In cases of debility, the proper remedies will be tonics and astringents, as tincture of iron, sulphuric acid and quinine. Pounded ice may be applied to the loins.

13. *Extirpation*.—The kidney has occasionally been excised, but the results of the operation are not encouraging. Professor Simon, of Heidelberg, performed it in 1869, upon a female, who had previously undergone ovariectomy with partial excision of the uterus, in which the left ureter was wounded, followed by a fistule in the wall of the abdomen and a constant flow of urine. It was to get rid of this distressing condition that the operation was undertaken. The incision through the integument extended from the inferior border of the eleventh rib as far as the middle of the space included between the last rib and the crest of the ilium, about six centimetres from the spine. The subcutaneous tissues and the aponeuroses of the internal oblique and transverse muscles having been carefully divided, and the outer margin of the long dorsal pushed aside, the quadratus, immediately over the kidney, was brought into view, and also divided. The cellulo-adipose tissue of the kidney was then split in its entire length, and the organ enucleated and removed, a ligature including a small portion of the hilus as a point of support having previously been thrown around the renal vessels. The extremities of the wound were united by sutures, the remainder being left open to promote drainage. The operation, which lasted about forty minutes, was followed by some fever, but this gradually subsided, and in less than two months the woman was perfectly well, the wound being so far healed as only to discharge occasionally a drop of pus.

In a case recently in the hands of Dr. Meadows, believed to be ovarian, but which, after the abdomen was opened, proved to be a large cyst of the kidney, and in which that gentleman excised the tumor, and applied a ligature, as in ordinary excision of the ovary, death occurred on the sixth day from hemorrhage of the pedicle. Dr. Linser, in 1871, extirpated the left kidney on account of a wound. The patient sank eight hours after the operation.

The principal morbid alterations of the *ureter* are deposits of tubercular matter and lymph upon its surface, thickening and attenuation of its walls, and contraction

Fig. 493.



Dilatation of the Ureter and Pelvis of the Kidney.

or enlargement of its cavity. Dilatation, as in fig. 493, from a preparation in my collection, is generally produced by the retention of a renal calculus, or by some tumor seated along the course of the tube, and interfering with the egress of the urine. In the male, it is sometimes caused by stricture of the urethra; in the female, by the pressure of a carcinomatous uterus. In a case of this description, which fell under my notice several years ago, the left ureter was fully as large as the thumb, with remarkable

thin, transparent walls. Occasionally the tube presents a singularly sacculated arrangement, some portions being greatly expanded, while others are very much contracted.

The ureter may be absent, or terminate in a cul-de-sac. When the bladder is wanting, it opens either into the urethra, vagina, or rectum. Occasionally, again, it is reduced to a small, narrow, almost impervious cord, which greatly impedes the passage of the urine.

Wounds and lacerations of the ureters are uncommon, and cannot be distinguished as separate and independent lesions. The effects are usually fatal, the most common causes of death being peritonitis and diffuse abscesses in the loin. From a paper, by Mr. Stanley, in the 27th volume of the *Medical and Chirurgical Transactions of London*, giving the particulars of two cases of ruptured ureter, one eventuating in recovery, and the other in death, it would appear that such accidents, when not immediately fatal, are sometimes followed by the formation of a cyst or pouch in the cellular tissue behind the peritoneum, serving as a reservoir for the urine. In both instances, the accumulation of fluid, which possessed all the properties of urine, was so great as to require repeated tapping. The cyst, in the fatal case, extended from the pelvis to the diaphragm, and communicated by a large, irregular aperture with the pelvis of the kidney. Death occurred in the tenth week after the accident, occasioned by a blow from the wheel of a cart.

The treatment of a wounded or lacerated ureter does not differ from that in similar injuries of the kidney. The measures must be strictly antiphlogistic, and no time must be lost in evacuating pent up fluid, whether simply purulent, or purulent and urinous.

SECT. II.—AFFECTIONS OF THE BLADDER.

EXAMINATION OF THE BLADDER AND URETHRA.

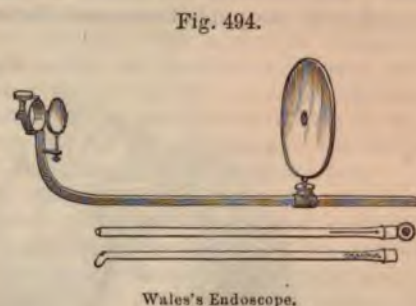
The urethra and bladder can only be satisfactorily explored with the bougie and the sound, either alone or assisted by the finger in the rectum. The proper methods of conducting the examinations will be pointed out in the sections on stricture of the urethra, stone in the bladder, and enlargement of the prostate gland. In ordinary diseased conditions of the urinary organs, the examinations, however, should not be limited to mere instrumental explorations. In both sexes, the most intimate sympathies exist between these organs and the neighboring structures, and in order, therefore, to make the investigation at all profitable, it should embrace the widest range possible, including, in fact, everything that may have the most remote bearing upon the subject. There is hardly an operation or accident, of any severity, in which the bladder does not suffer more or less from loss of power; and spasm of this viscus and of the urethra is a very common occurrence in all organic affections of the anus, rectum, and uterus. If, then, a surgeon should restrict his examination to the urinary organs, he would fall far short of his duty, especially in cases of chronic disorders.

During the past twenty years various attempts have been made to facilitate the diagnosis of vesical and urethral affections by means of instruments through which the interior of these structures could be lighted up and inspected. The credit of

having first suggested the endoscope, as the contrivance with which the examination is conducted is termed, is due to Mr. Avery, of London, but its employment was popularized by Desormeaux, of Paris, and Creuse, of Dublin, who have brought it to its present state of perfection.

Dr. Philip S. Wales, of this city, has devised an endoscope, exhibited in the annexed sketch, fig. 494, which possesses the great advantage of combining cheapness with simplicity of arrangement. The illumination is effected by means of a concave mirror, three inches in diameter, and of ten inches focal length, perforated at its centre. The mirror is supported upon a metallic bar, connected with the exploratory tubes, and capable of adjustment by a sliding movement. The best light is that of the sun, but, in the absence of this, a Tobold's modification of the common reading lamp, fed with magnesium wire, may be used, as this affords a most brilliant illumination.

After a fair trial with this instrument surgeons have very generally concluded that it is practically of little utility. Although strictured, granular, and ulcerated conditions of the urethra may be seen and indicated through its agency, and small portions of vesical calculi and tumors be illuminated, yet the diagnosis of these affections is as readily effected with the ordinary sound or bougie, the use of which is free from the embarrassment and pain attendant upon the employment of the endoscope. From the large size of the tubes and the irritation which they produce, the disease is more likely to be aggravated than relieved.



MALFORMATIONS.

The bladder is liable to various malformations, but almost the only one of any surgical interest is exstrophy, consisting essentially in an absence of the anterior wall of the viscus, complicated with certain defects of the genital apparatus. The occurrence is much more common in males than in females. Of 16 cases that have come under my notice, all, except 2, were males. Of 9 cases observed by Mr. McWhinnie, of London, 7 were males, and 2 were females. Mr. John Wood has met with upwards of 20 cases, of which only 2 were females.

The urinary tumor, situated at the lower part of the abdomen, is generally somewhat ovoidal or globular. Its volume is greatly influenced by the age and position of the subject. In the child, it rarely exceeds that of a walnut, while, in the adult, it may be as large as a fist, or a goose's egg. Very small, when the subject is recumbent, it becomes very prominent when he stands up, coughs, sneezes, or exerts himself. The surface of the tumor is of a bright red color, and is constantly covered with mucus, which thus protects it, in some degree, from the injurious impression of the atmosphere. In elderly subjects, and occasionally even in young ones, it is sometimes partially invested with a cutaneous pellicle, in consequence of which it is much less sensitive, irritable, tender, and liable, than under ordinary circumstances, to bleed. The orifices of the ureters, generally situated at the inferior part of the tumor, are each marked by a small, conical eminence, from which the urine constantly dribbles, rendering the person uncomfortable to himself, and disgusting to those around him. The distance between the two apertures ranges from one to two inches, according to the age of the subject.

The penis, abnormally short and flattened, is bent backwards, and furnished with an imperfect prepuce. The cavernous bodies, attached below to the ischium, as in the natural state, are small and narrow, and are not always united along the middle line, except just behind the head of the penis. This organ is sometimes imperforate, while at other times it presents a gutter along its upper surface for the lodgment of the lower half of the urethra. When this is the case, the posterior part of the canal displays the verumontanum, the mouths of the ejaculatory ducts, and the orifices of the prostatic canals. From the peculiar conformation of the penis and urethra, the individual is necessarily impotent. The prostate gland is generally in a rudi-

mentary state. The seminal vesicles are also very diminutive, and are invariably situated behind the inferior part of the tumor. The ejaculatory ducts pursue their natural route, but are unusually small.

The scrotum is sometimes absent; at other times it exists merely in a rudimentary state. In the latter case, it may contain the testicles, while in the former, these organs are either lodged in the groins, or in a cutaneous bag at each side of the tumor. The testicles are either normal, wanting, or much diminished in volume. The bodies of the pubic bones are absent, the pelvis is unusually broad and flat, and

Fig. 495.



Exstrophy of the Bladder. *a*. Everted Bladder. *b, b*. Orifices of the Ureters. *c*. Penis without Urethra. *d, d*. Pubic Symphysis. *e*. Scrotum and Testis. *f, f*. Congenital Inguinal Hernia.

the groins are generally the seat of hernia. Fig. 495, taken when the patient was upwards of twenty years of age, affords an excellent idea of the ordinary appearances of this species of malformation.

In the female, equally important changes are noticed in the genital organs. Thus, the clitoris may be absent, or deviate remarkably from the normal standard; the nymphæ are small and disjoined, and the labia extend from the sides of the tumor towards the anus, without coalescing behind. The uterus and ovaries are either absent, or they exist in a rudimentary state. Sometimes, however, these organs are fully developed, as is shown by the fact that the woman both menstruates and conceives, as in the interesting cases reported by Thiebault and Ayres.

Persons affected with this deformity may, notwithstanding their constant discomfort, live for many years, and even attain longevity. Head, whose case is well known in this country, is now upwards of forty years of age, and in the enjoyment of excellent health. Flajani has recorded a case of seventy, and Quatrefages met with two, respectively, forty-six and forty-nine years of age.

In a still-born female child, kindly sent to me by Dr. Bournonville, there was complete absence of the vagina, and the merest vestige of nymphæ. The deficiency in the wall of the abdomen at the umbilicus was unusually great. The child was well formed in all other respects.

Exstrophy of the bladder was, until lately, universally regarded as utterly irremediable. In fact, even now, after all the lights of modern science, all that can generally be done is to palliate suffering by attention to cleanliness, and by the use of a closely-fitting shield of gutta-percha, furnished with a bottle for receiving the urine. When this cannot be obtained, the part must be kept constantly covered with a thick, soft compress, renewed as often as it becomes wet and disagreeable. The skin around may, if necessary, be protected with suet, pomatum, or zinc ointment.

It was proposed some years ago to establish a channel for the conveyance of the

urine from the bladder to the rectum, and, in one instance, that of Mr. Simon, of London, the plan was partially successful in diminishing the incontinence. The operation consisted in making the ureters open into the bowel, by passing instruments, armed with threads, from the former into the latter, the ends being tightened from time to time until the communication was effected. The boy lived nearly a year, when death ensued from disease of the ureters and kidneys. In the cases of Mr. Lloyd and Mr. Athol Johnson, in which an effort was made to open a direct communication between the bladder and rectum by means of a seton, the patients perished in a few days from peritonitis. Mr. Holmes, with a view to obviate the risk of peritonitis, has devised a plan of converting the bladder and bowel into a common cavity, by destroying the intervening tissues of the perineum above the sphincter muscle. The blades of the instrument, which are constructed on the same principles as those of the enterotome, are applied to the bladder and the rectum, and approximated from day to day until the sloughing process is completed.

Occasionally an attempt has been made to form a cover for the tumor by autoplasty, by borrowing the integument from the adjacent parts, and inverting it in the hope that the cutaneous tissue might ultimately assume the properties of the mucous, and so adapt itself to its new relations. The flaps are united by suture, and are thoroughly protected during the treatment from the contact of the urine. The extensive wound in the neighborhood should be as well closed as the case may admit of, the bowels should be locked up with morphia, which should also be freely used to allay pain, and the walls of the abdomen should, throughout, be maintained in a relaxed condition by placing the patient almost in a sitting posture, with the knees well supported by pillows. The greatest possible attention must also be bestowed upon cleanliness.

Of the different operations for covering in the bladder, in this affection, the most eligible for males is that of Dr. F. F. Maury, represented in fig. 496, the flap being made at the expense of the perineum and scrotum, by a curvilinear incision carried from the outer third of Poupart's ligament, across the middle of the perineum, to a corresponding point on the opposite side, and united, after bevelling its surfaces, by the tongue and groove suture, to an upper short flap, raised by dissection from the abdominal walls just below the umbilicus into which it is inserted. The penis is slipped through a small incision made in the centre of the flap, through which the urine passes off without coming in contact with the edges of the wound. In this way Dr. Maury succeeded in two cases not only in forming an anterior wall for the bladder, but in curing a double hernia by the contraction of the exposed granulating surfaces. It is proper to add that the patients were, respectively, eight and nine years of age. In females the procedure of Professor Wood, which consists in inverting an umbilical flap over the viscus, and covering it in with a flap raised from each groin, is preferable to other methods hitherto devised.

The unfavorable opinion expressed in former editions of the value of this operation has, I must candidly confess, been greatly modified by the results obtained within the past few years, since I am convinced, from a personal examination of several cases, that it affords great comfort not only by protecting the sensitive mucous membrane from the contact of the clothing, and preventing excoriation of the surrounding parts, but also by facilitating the adjustment of an apparatus for receiving the urine. The great danger after the operation is erysipelas, likely to eventuate in sloughing of the flaps; but in addition to this there will certainly be some risk both of peritonitis and pyemia. Much of this danger, however, may be avoided by proper preliminary treatment.

To Professor Pancoast is undoubtedly due the credit of having been the first, in 1858, to perform a successful plastic operation for the relief of this malformation. The patient, a man, twenty-eight years of age, recovered completely, but died of pneumonia two months and a half subsequently. The operation was repeated, in a modified form soon afterwards, by Dr. Ayres, of Brooklyn, upon a young woman,

FIG. 496.



Maury's Operation for Exstrophy of the Bladder.

with highly gratifying results, a urinary canal and an anterior fourchette of the vulva having been established. Similar operations have been performed within the last few years, by Holmes, Wood, Billroth, Barker, Ashhurst, Bigelow, and Hodges, affording an aggregate of 23 cases, of which 18 were successful, 4 were failures, and 1 was fatal.

WOUNDS.

Wounds of the bladder, whether incised, punctured, lacerated, or gunshot, must necessarily, from the situation of the viscus, be complicated with lesion of the soft parts by which it is surrounded, and also not unfrequently with fracture of the pelvic bones.

The best example of an incised wound of the bladder is the incision, made in the supra-pubic and recto-vesical operations for stone. In perineal lithotomy, the knife divides the prostate gland rather than the bladder. A good example of a punctured wound is afforded by the use of the trocar in drawing off the urine for the relief of retention from obstruction of the urethra.

The symptoms are, the existence of an opening in the lower part of the hypogastrium, groin, or perineum; sudden and acute pain in the situation of the affected organ, extending along the urethra, and often accompanied by slight priapism; an escape of urine, or urine and blood, at the external wound; frequent, but ineffectual, attempts at micturition; violent tenesmus; and hemorrhage from the urethra. The system labors under all the effects of violent shock. When the injury is complicated with perforation of the bowel, fecal matter, mucus, bile, or gas, mixed with urine, or urine and blood, may issue both at the external opening and at the urethra. When the pelvic cavity is pierced, the state of collapse, the usual consequence of the accident, is speedily followed by symptoms of peritonitis, of which the patient almost always dies in a few days.

When the bladder is wounded through the perineum or above the pubes, at a point where it is uncovered by serous membrane, urinary infiltration is liable to take place, and the probability of the occurrence will be so much the greater if the external opening is disproportionately small, if the track of the wound is narrow and devious, and if the organ was much distended at the time of the accident.

Gunshot wounds of the bladder, less fatal, perhaps, than punctured and incised, are always extremely formidable, destroying the patient immediately or remotely, producing extensive mischief among the soft parts, as well as in the pelvic bones, and leading to the formation of abscesses, sinuses, and fistules, which may last for an indefinite period. When the ball is impelled with great velocity, it will be apt to enter the organ at one point, and pass out directly opposite at another, thus leaving two apertures, and either lodging in the neighborhood, or issuing at the surface of the body. If, on the contrary, it move slowly, or be nearly spent, it will make only one opening, and be arrested in the bladder, from which it may afterwards be discharged by the urethra, or by a fistulous passage; or, what is more probable, it will become incruusted with earthy matter, and thus form the nucleus of a calculus. The lesion is often complicated with fracture of the pelvic bones, injury of the large vessels, and perforation of the rectum, small intestines, uterus, or vagina. In the former case, serious mischief is sometimes done by the osseous splinters which the ball makes and detaches in its course towards the bladder, and which not unfrequently find their way into the interior of this organ, where they may give rise even to more disastrous consequences than the ball itself. Wadding, pieces of cloth, or portions of the patient's dress, may accompany the ball.

Gunshot wounds of the bladder, made with the old round bullet, were formerly frequently recovered from. Thomson met with not less than 14 cases of this kind after the battle of Waterloo, and Guthrie refers to 6 similar examples, in 3 of which the bullet entered above the pubes. Larrey, who met with a number of instances of gunshot wounds of the bladder in Egypt and Syria, affirms that they generally terminated favorably. This, however, is not the experience of recent military surgeons, for wounds inflicted upon this organ by the Minié ball nearly always cause death. Now and then, however, an exception occurs, as in the case of a young man, reported to me by Dr. J. F. Koerper. He was struck by two Minié balls, one of which entered the right buttock, nearly midway between the great trochanter and

the sacral fissure, and emerged at the left groin, traversing, apparently, the lower part of the bladder, which had not been emptied for upwards of eight hours. Urine began to issue at the gluteal wound soon after the accident, and for six days it passed off entirely by this route. It then gradually resumed its natural channel, but it was not until after the end of a month and a half that the fistulous track was finally closed. The man never had any bad symptoms. In a case mentioned by Dr. F. H. Hamilton, the individual had seven wounds, from three of which, made apparently with buckshot, all the urine escaped for ten days. It then ceased to pass off by the posterior openings, but continued to flow from the anterior for six weeks. The recovery was complete. One of the great causes of death in gunshot injuries of the bladder, involving the pelvic bones, where the patient does not perish from the immediate effects of the lesion, is pyemia.

The prominent indications of treatment are, to prevent the extravasation of urine, and to guard against undue inflammation. Unfortunately, the first of these accidents often takes place at the moment of the injury, and, consequently, before the surgeon has an opportunity of interfering. When the reverse is the case, the bladder should instantly be evacuated, the patient placed almost semierect in bed, and a gum-elastic catheter permanently retained to allow the urine to pass off as fast as it descends from the ureters. In a word, the organ should be kept constantly empty and contracted for the first few weeks, or until there is reason to conclude that the wound is closed and that all risk of infiltration is over. In the more favorable cases most, if not all, of the fluid escapes through the accidental passages, thereby greatly favoring recovery.

Inflammation is prevented by local bleeding, calomel and opium, fomentations, and vesication of the abdomen. Anodynes are given in full and sustained doses, both by the mouth and by the rectum, to mitigate pain and spasm of the bladder, promote sleep, and diminish the renal secretion. Hardly any drink is admissible; the diet must be very light and bland, and the bowels must be disturbed as little as possible during the first fortnight. Abscesses, the result of urinary infiltration, are opened by early and free incisions.

Nothing can be gained by an attempt to extract the foreign body in injury produced by firearms; for the very moment it is inflicted the urine escapes, and the bladder, contracting upon itself, destroys the relations between the external and internal wounds. If the ball has fallen into the bladder, it may, if not too large, either pass off spontaneously, as in the cases recorded by Larrey, Baudens, and Bonnet, or it may be removed with the forceps, otherwise, especially if it cause severe symptoms, it must be cut out through the perineum by an operation similar to that of lithotomy. This may be done immediately, or within a short period after the accident, if the ball has entered beneath the pubes, for the reason that the organ will not only be freed thereby of a disagreeable intruder, but also because there will be less risk of urinary infiltration.

Mr. Dixon has published an analysis of 13 cases, in which the lateral operation of lithotomy was performed for the removal of bullets. Of these, 10 were successful, and 3 fatal. Baudens, in a similar instance, relieved his patient by the supra-pubic operation. Hildanus has recorded a case in which a bullet remained in the bladder for thirty years.

Pieces of wadding, of cloth, and of bone, introduced into the bladder, either alone, or jointly with a ball, are occasionally voided by the urethra. More generally, however, if the patient survive the immediate effects of the accident, they are retained, and become the nucleus of a calculus. The presence of such bodies is usually easily detected with the sound.

When the bladder has been transfixed, or wounded through the peritoneum, the accident is almost inevitably fatal. All the cases that occurred during the late war had this termination. In view of this event, would it be proper to make an incision through the linea alba, and sponge out the extravasated fluid? My opinion is that it would, on the ground that it would be much more creditable to a surgeon to perform such an operation, provided it can be done immediately after the infliction of the injury, than to stand by and see his patient perish from the effects of peritonitis. The only difficulty might be the uncertainty of the abdominal effusion. Relief might promptly be afforded, under such circumstances, by the rectal puncture, as originally suggested by Dr. Harrison, as the tendency of the urine is to settle in the pelvic cul-de-sac.

LACERATION.

The urinary bladder is liable to laceration. When the accident takes place from overdistention of urine from paralysis of the muscular fibres of the organ, hypertrophy of the prostate gland, or obstruction of the urethra, there is always some degree of softening of the different coats, thus predisposing them to the occurrence. In such a case, any unusual, sudden, or violent exertion may produce it.

The most common cause of laceration, however, is external violence, and it is worthy of remark, both in a surgical and medico-legal point of view, that it may occur from the most trivial injury. Any force suddenly applied to the hypogastric region, while the bladder is distended, as a smart blow, a kick, or a fall, will frequently suffice to produce it, sometimes without leaving the slightest trace upon the surface of the body; not, perhaps, even any discoloration. The accident is liable to happen in females during parturition, from the pressure of the child's head, when the patient has neglected to empty the bladder. It may also be occasioned by fracture of the pelvic bones, the ends of the fragments being forcibly driven into the walls of the organ, as in a case which I saw along with Dr. John W. Lodge, in a young man, who was hurt by a mass of sand caving in upon him while at work in a quarry. No marks of external injury existed, but the pubic and ischiatic bones were most extensively fractured, especially the former. The prominent symptoms were, severe pain in the lower part of the abdomen, groins, and sacrolumbar region, excessive nausea and vomiting, great swelling of the perineum, scrotum, and right thigh, from urinous infiltration, and inability to empty the bladder. Death occurred two weeks after the accident, from the consequent effects of peritonitis and gangrene. The perineum and scrotum, as well as the tissues in front of the prostate gland and the rectum, were nearly entirely destroyed, and the penis was almost completely severed from its attachments at the pubic symphysis.

Of 37 cases of rupture of this organ by external violence, collected by Houël, 15 involved the posterior and 12 the anterior wall, 3 the sides, and 2 the summit; 3 were double, and in 2 the situation is not stated. Rupture of the posterior wall nearly always extends through the peritoneum, whereas, in the other forms of the accident, this membrane generally remains intact. Of 78 cases, analyzed in 1851, by Dr. Stephen Smith, the posterior wall suffered in 50, the anterior wall in 9, and the neck in 6. The cause of the rupture in 48 was direct violence; in 15, concussion; in 4, parturition; and in 4, stricture of the urethra. Sixty-seven of the cases were males, and eleven were females. Death, in the majority of the patients, occurred within the first five days; 5 recovered, and 1 lived six weeks.

In laceration of the front of the bladder, the urine, if the opening be large, escapes rapidly, and spreads widely beneath the peritoneum; sometimes as high up, on the one hand, as the umbilicus and the kidneys, and, on the other, as low down as the thigh, by passing through the obturator foramen. In spontaneous rupture from overdistention, the bladder generally gives way in its posterior wall, without involvement of the peritoneum, and the consequence is that the urine accumulates under this membrane as in a kind of subsidiary pouch.

The injury usually reveals itself by well marked symptoms, both general and local. Violent pain is instantly experienced in the hypogastric region, the face is pale and ghastly, the pulse is small, rapid, and fluttering, the respiration is hurried and difficult, the extremities are cold, and the surface is covered with a clammy perspiration. The patient occasionally falls down in a state of insensibility, and not unfrequently he feels as if something had suddenly given way in his abdomen. There is, in nearly all cases, a constant desire to urinate, with an inability to pass a single drop of water. A small quantity of blood often flows off by the urethra. These symptoms are soon followed by nausea and vomiting, intense thirst, excessive restlessness, and an expression of great suffering, with swelling and tenderness of the abdomen.

Rupture of the bladder, as above stated, is nearly always fatal; usually in from three to five days after its occurrence. The immediate sources of danger are, hemorrhage, shock, peritonitis, and uremia, generally promptly collapsing the system.

The treatment must be conducted in accordance with the general principles laid down under the head of wounds of the bladder. The only reliance is upon the catheter, anodynes, and supporting measures.

INFLAMMATION.

Inflammation of the bladder, technically termed cystitis, generally begins in the mucous membrane, and presents itself under two varieties of form, the acute and the chronic. Of these, the first is exceedingly infrequent, while the second is sufficiently common, and often entails a vast amount of suffering.

1. *Acute Cystitis*.—Acute inflammation rarely occupies the whole mucous surface of the bladder; on the contrary, it usually occurs in irregular, circumscribed spots, from the size of a twenty-five cent piece to that of the palm of the hand. Any portion of the organ is liable to suffer, but the parts most frequently affected are the neck and bas-fond. During its progress, the inflammation often spreads from the mucous membrane to the subjacent cellular tissue, and from thence to the muscular tunic. The peritoneal investment is rarely implicated in any considerable degree, however serious the attack.

In cystitis consequent upon an extension of gonorrhœa, the inflammation generally comes on during the height of the discharge, as a direct result of the use of stimulating food and drink, severe bodily fatigue, or irritating injections. Occasionally, however, it sets in at a comparatively late period, when nearly all discharge has disappeared, and the patient considers himself almost well. The parts usually affected are those immediately behind and below the prostate gland, which not unfrequently participates in the morbid action.

The principal causes of acute cystitis are wounds of the bladder, calculous concretions, gonorrhœa, rough horseback exercise, the inordinate use of heating drinks, venereal excesses, enlargement of the prostate gland, stricture of the urethra, congenital smallness of the external meatus, injury sustained during parturition, stimulating diuretics, suppression of the cutaneous perspiration, irritating injections, and the protracted retention of urine.

The more important anatomical characters are, increased vascularity, loss of transparency, softening, deposits of lymph, and discoloration, with alteration of the natural secretion.

The malady is generally ushered in by bold and well marked symptoms. The first circumstance that usually attracts attention is a dull, obscure, deep-seated pain, or, rather, a kind of gnawing uneasiness, in the region of the bladder, which, rapidly increasing in intensity, soon extends to the neighboring organs. At this early stage, there is little or no constitutional disturbance; or, if there be any, it manifests itself merely by slight chills, alternating with flushes of heat, some thirst, and a little excitement of the pulse. The patient now begins to experience frequent calls to void his urine, which is expelled either in small quantities, or drop by drop, accompanied with violent straining, distressing spasm, and a peculiar scalding sensation at the neck of the bladder and along the course of the urethra. The hypogastrium is distended, painful, and so exquisitely tender as to render even the weight of the bed-clothes intolerable. The limbs are drawn up, and the body is bent forward, to relax the abdominal muscles, and relieve the tension of the bladder. The urine is scanty, thick, ropy, turbid, reddish, or tinged with blood, and loaded with urates and mucus. After a few days, suppuration occurs, and then the fluid invariably contains more or less pus and fibrin. The pain, always so distressing a symptom, shoots along the testicles, groins, thighs, and spermatic cords, to the sacrolumbar region, where it is often almost insupportable. The bladder, never entirely freed of its contents, gradually ascends above the pubes into the hypogastrium, forming an elastic, globular tumor, exquisitely sensitive under the slightest pressure, and readily detectable by sight and touch.

When the disease is fully developed, there is always more or less constitutional derangement, as indicated by the frequency and hardness of the pulse, the anxious countenance, and the coated appearance of the tongue. Nausea and vomiting, with severe precordial oppression, are rarely absent. Sometimes there is complete suppression of urine.

Considerable diversity occurs in the symptoms of cystitis, dependent upon the particular seat of the morbid action. When the neck of the bladder is mainly affected, excessive pain and a sense of weight and fullness are experienced in the anus and perineum, there is obstinate retention of urine, with an incessant desire to micturate, and severe scalding is felt along the urethra. When the anterior wall is inflamed, there is great tenderness on pressure and percussion, with a sense of constriction

in the hypogastric region. When the disease occupies the base of the organ, the rectum always suffers severely, the patient is harassed with constant straining and tenesmus, and there is exquisite tenderness on pressure of the perineum.

Acute cystitis usually runs its course with considerable rapidity. It seldom continues beyond the sixth or eighth day without terminating in resolution, tending to suppuration, passing into gangrene, or assuming a chronic type.

The leading indications in the *treatment* are, first, to subdue symptomatic excitement, and, secondly, to quiet local irritation. For accomplishing the first, the remedies mainly relied upon, in the incipient stages of the complaint, are general and topical bleeding, aperients, and diaphoretics, aided by the antiphlogistic regimen. The bowels, if distended, should be early moved by some mild laxative, as castor oil, Rochelle salt, sulphate of magnesia, or, what is better, by an enema of cold water, thin gruel, or soapsuds. If the biliary and other secretions are deranged, a dose of calomel may advantageously be given. All drastic cathartics must be avoided, as they tend not only to excite the inflamed structures, but to increase the quantity of irritating matter in the urine.

As soon as proper depletion has been practised, diaphoretics are to be given, and the one which I have found most useful is the antimonial and saline mixture, in union with full doses of morphia and aconite. Dover's powder is beneficial when the skin is already soft. If the stomach is irritable, the effervescing draught is preferable to everything else. The action of these medicines may be favored by tepid drinks, the hot vapor-bath, and hot fomentations to the hypogastrium and genitals. Diuretics are improper. When the urine is acrid, high-colored, or very scanty, a small quantity of nitrate of potassa, or spirit of nitrous ether, mixed with some demulcent fluid, may be administered, to modify the renal secretion and to allay vesical irritation. In the latter stages of the disease, a strong infusion of uva ursi and hops will prove highly advantageous, especially if combined with morphia and bicarbonate of soda, or morphia and balsam of copaiba. The use of balsam of copaiba is particularly indicated in the gonorrhœal form of the complaint.

Among the more important local remedies for arresting cystitis and tranquilizing the affected organ, are leeching, anodyne suppositories, fomentations, and the hip-bath. The pain in the back is relieved by cups, either wet or dry, applied to the sacrolumbar region. Certain modifications of treatment are made, according to the nature of the exciting cause of the disease. Retention of urine is promptly relieved by the catheter, but the instrument must not, for obvious reasons, be retained in the bladder.

2. *Suppuration and Abscess.*—A discharge of pus, or muco-purulent fluid, from the lining membrane of the bladder, although sufficiently common in chronic cystitis, is infrequent in the acute form of the disease. The discharge, moreover, is usually of brief continuance, as well as small in quantity, while in chronic cystitis it often lasts for a long time, and is occasionally remarkably profuse.

The matter, instead of being furnished by the free surface of the mucous membrane, occasionally presents itself as a small abscess, situated in the submucous cellular tissue, or between the muscular and serous tunics. It may occur in any part of the viscus, but is most frequent at its neck, as a solitary deposit. Although in the great majority of cases the abscess points inwards towards the cavity of the bladder, it may also open into the rectum, the sigmoid flexure of the colon, the ileum, the vagina, or the abdominal cavity. Sometimes the matter is diffused through the connective tissue of the coats of the viscus, which, in consequence, exhibit a soft, œdematous aspect.

Suppuration of the bladder may be the result of idiopathic inflammation, either acute or chronic, external violence, or the presence of some foreign body, as a calculus, bougie, or catheter. In the latter case, the abscesses are generally developed under the influence of protracted irritation, operating directly upon the tunics of the organ.

The occurrence of suppuration is always denoted by well marked symptoms. The most important are frequent rigors, alternating with flushes of heat; an increase of thirst, anxiety, and restlessness; dull, aching, throbbing pain; and a feeling of weight and fullness in the perineum and pelvis. The mind generally wanders, and, in many cases, there is confirmed delirium. These symptoms, however, may be simulated by other diseases, both of the bladder and of the neighboring organs. In abscess, the diagnosis is sometimes determined by the sudden appearance in the

urine of a large quantity of pus, after a violent effort at micturition, or an attempt to draw off the urine. Infiltration of pus into the coats of the bladder cannot be distinguished during life.

The prognosis of suppuration of the bladder is usually favorable, except when it ends in abscess, when the danger is always imminent. Much, however, must necessarily, under such circumstances, depend upon the nature and extent of the mischief.

The treatment is by antiphlogistics, in the earlier stages of the disease, and, subsequently, by tonic and invigorating measures. Abscesses, pointing externally, must be opened with the knife.

3. *Gangrene*.—Acute inflammation of the bladder seldom ends in gangrene, as the morbid action which gives rise to it is generally easily arrested by the early and vigorous employment of antiphlogistic measures. The occurrence is particularly to be apprehended when the disease is marked by great violence, when it has been induced by external injury, and when it takes place in old, dilapidated subjects.

Gangrene of the bladder, although it may arise as a consequence of idiopathic inflammation, is almost always the result of external violence, of overdistention by urine, or of compression during the descent of the child's head in parturition. It occasionally follows upon the operation of lithotomy, and the injudicious employment of instruments.

However induced, the occurrence is announced by great prostration of strength; sudden cessation of pain; coldness of the extremities; small, weak, frequent, and tremulous pulse; profuse, clammy, and offensive perspiration; cadaverous expression of the countenance; mental confusion, delirium, and coma; hiccup, twitching of the tendons; and, towards the close, by colliquative diarrhoea and involuntary discharge of the feces. The urine is of a dark-brownish, or blackish color, emits a peculiarly fetid, sickening odor, and is effectually retained by the dead, crippled, or paralyzed organ. On dissection, the mucous membrane is found to be blackish, livid, or purple, very soft, easily torn, and bathed with a thin, sanious fluid, of an excessively offensive odor.

Gangrene of the bladder is sometimes followed by a rupture of its coats, and the escape of its contents. Such an event is most likely to happen when there has been protracted retention of urine, with inordinate distention, and it may occur either very suddenly, or slowly and gradually, as a result of ulceration. Whether the urine escapes into the cavity of the abdomen, or into the cellular tissue of the pelvis, death is equally certain.

The treatment is easily told. The object should be to prevent the lesion rather than to attempt to cure it after it has been established. When gangrene is inevitable, the indication is to support the system, and, by means of quinine, ammonia, brandy, opiates, and nutritious food, assist the patient in throwing off the effects of the local disorder. Distention of the bladder is relieved with the catheter.

4. *Ulceration*.—Ulceration of the bladder is amongst the rarest accidents to which this organ is liable. The ulcers are usually neither numerous nor large. Their most common appearance here, as in the bowels, is that of depressed breaches of continuity of the mucous membrane, of a circular or oval form, with slightly elevated edges. Occasionally, the edges are hard, thick, fissured, and puckered. Occurrences like these are most common in old, chronic cases. The bottom of the erosion is originally formed by the submucous cellular substance; but as the disease progresses it may destroy the muscular fibres, and even the serous investment, leading, perhaps, eventually to perforation, and to the escape of urine into the abdominal cavity. Or, instead of this, adhesions may take place between the bladder and the neighboring viscera.

In the great majority of instances, the ulceration is distinctly traceable to chronic cystitis. Paralysis of the bladder, injury of the spinal cord, and organic lesion of the kidneys, are very apt to induce the affection, from the changes which they create in the composition of the urine. Calculous concretions and earthy deposits often occasion ulceration solely by the pressure which they exert upon the mucous membrane. Sometimes the disease is the result of the softening of tubercular matter, and then the muscular fibres are occasionally as completely denuded as if they had been dissected with the knife.

The symptoms of ulceration of the bladder do not differ essentially, in the early

stage of the disease, from those of subacute or chronic inflammation. Even at a later period, they are not always well marked. The most prominent are pain and uneasiness in the pelvis, with anal and vesical spasm, frequent micturition, and an offensive state of the urine. The pain is of an acute, burning, or scalding character. The inclination to micturate is not incessant, but in paroxysms, which gradually increase in frequency, and are attended with intense suffering. The urine is commonly acid, slightly albuminous, voided in small quantity, and loaded with thick, ropy mucus, which, as the fluid cools, adheres firmly to the bottom of the receiver. As the destruction of the lining membrane proceeds, the mucus gradually diminishes, and finally almost entirely disappears. In the advanced stages of the complaint, the fluid is excessively offensive, of a dark color, occasionally like coffee-grounds in appearance, and often mixed with pus, blood, shreds of lymph, and even the debris of the affected membrane. An ammoniacal state of the urine is not uncommon at this period. Hemorrhage in considerable quantity may occur when the ulceration opens a bloodvessel.

As the disease progresses, the sympathies and functions of the urinary organs are completely subverted, and the patient's health is materially impaired by the local derangement. Sometimes, however, on the other hand, the symptoms are comparatively mild, and but little distress is experienced in the urinary apparatus. This is more particularly true when the disease is of a tubercular character.

The diagnosis is not only difficult, but sometimes impracticable. The affections for which the disease is most liable to be mistaken are simple cystitis, catarrh, and stone. From the first, it may generally be distinguished by its obstinate persistence, by the greater extent and violence of the local distress, by the incessant desire to void the urine, by the more frequent recurrence of spasms, by the more severe burning or scalding along the urethra, and lastly, by the presence of pus in the urine, and, in the more aggravated forms of the complaint, by the absence of mucus. In catarrh, the characteristic symptom is a copious secretion of thick, tough, ropy mucus, with a turbid appearance and an ammoniacal smell of the urine. The local and constitutional distress are less severe than in ulceration, the desire to micturate is not so frequent, there is less sensibility of the urethra, and there is often complete intermission of the vesical disturbance, the patient remaining comparatively comfortable for days and weeks. In ulceration, the symptoms are persistent, the disease steadily proceeding from bad to worse.

In stone, the pain is most severe immediately after micturition, and is generally much aggravated by rough exercise; the urine is more frequently bloody; there is less irritability of the urethra; and the intervals between the paroxysms are longer than in ulceration. If doubt exists, the sound is used, cautiously and gently, lest, if the case be one of ulceration, it increase the local inflammation, and thus endanger life.

In ulceration there is sometimes a discharge of the debris of the mucous membrane, which never happens in simple cystitis, catarrh, and calculous disorder. The pain also is much greater, and the desire to pass water more frequent. When perforations exist, a discharge of gas, fecal matter, ingesta, and other substances, along with the urine, leaves no doubt respecting the nature of the disease.

The *treatment* is most unsatisfactory. At the commencement of the complaint the measures must be strictly antiphlogistic. Depletion by the lancet will, however, seldom be called for, while the local abstraction of blood by leeches is proper in almost every stage of the disorder, and constitutes, indeed, one of the most valuable therapeutic resources. The bowels are maintained in a soluble condition by mild aperients, the diet should be light but nutritious, the body is incased in flannel, and all rough exercise is carefully avoided. The most suitable internal remedies are, balsam of copaiba, uva ursi, hops, cubebs, hyoscyamus, bicarbonate of soda, mineral acids, and tincture of chloride of iron, either alone, or variously combined. Anodynes, in full doses, are indispensable for quieting the bladder, and procuring sleep.

Of the measures addressed directly to the affected surface the best, undoubtedly, are such as are of an anodyne character, as infusion of poppy, opium, hop, aconite, and cicuta, or tepid water, either simple or medicated with tar, tannic acid, sulphate of zinc, creasote, or nitrate of silver. Lime-water, black wash, and weak solutions of iodine have occasionally proved advantageous. The best mode of introducing them is by means of a gum-elastic bag, carefully adapted to the end of a medium sized flexible catheter. The quantity of any injection should not exceed, at first,

an ounce; if it be anodyne, it should be retained as long as possible; if astringent, or irritating, not more than a few minutes. No form of counter-irritation is likely to be of the least service.

Finally, the only really rational treatment in ulceration of the bladder unquestionably is to open the organ through the perineum in order to place it in a state of thorough repose until the sores are completely cicatrized. Great difficulty, however, would be likely to be experienced in keeping the wound open sufficiently long to attain this end. In the female, who is particularly liable to perforative ulceration of the neck of the bladder, the late Sir J. Y. Simpson succeeded perfectly in two cases in effecting a speedy cure after the failure of a great variety of other means by slitting up, upon a grooved staff, the posterior fourth of the urethra and about one inch of the posterior wall of the viscus. Dr. Bozeman, in 1860, in a case of most extensive ulceration of the bladder, made a large opening into the vesico-vaginal septum, and eventually completely relieved his patient. Emmet and Parvin have also performed the operation successfully. To Mr. Guthrie, of London, is due the credit of proposing this mode of treatment, which, so far as I know, was first carried into effect by Dr. Willard Parker, of New York.

5. *Chronic Inflammation, Catarrh, or Cystorrhœa.*—Catarrh of the bladder, technically denominated cystorrhœa, signifies an inordinate secretion of white, glairy mucus, essentially dependent upon chronic inflammation of the lining membrane. It is analogous in its character to gleet, leucorrhœa, and kindred affections, and is generally merely a symptom of a more serious disease. It may occur at any period of life, but is most common in elderly subjects, and is nearly always due to some obstacle to the evacuation of the urine, as stricture of the urethra, vesical calculus, enlargement of the prostate gland, or paralysis of the bladder. It is a constant attendant upon sacculation, ulceration, hypertrophy, and carcinoma of the organ. Once established, it is easily aggravated or reinduced by exposure to cold, excesses in diet, irritating injections, diuretics, overdistention of the bladder, neuralgia, retrocession of gout, repulsion of cutaneous eruptions, local injury, and disease of the adjoining parts, as the anus, rectum, vagina, and uterus.

The disease generally comes on in a slow, gradual, and insidious manner. The inflammation which accompanies it, and which is always the immediate cause of the peculiar discharge, is of a chronic character, and, in the first instance, of a very mild grade. It is for this reason that the term subacute has sometimes been applied to it. The characteristic symptoms are, an inordinate secretion of mucus, an altered condition of the urine, frequent and difficult micturition, pain in the region of the affected organ, as well as in the adjoining parts, and more or less constitutional derangement. The quantity of mucus that is mixed with the urine varies remarkably in different cases and in different conditions. In the incipient stages, and in the milder forms of the affection, it is generally small, not exceeding, perhaps, a few drachms in the twenty-four hours. At a more advanced period, the quantity is often considerable, and in some instances it is truly enormous. The secretion is usually very thick, ropy, and viscid, and, after standing for some time, it always adheres firmly to the bottom of the receiver.

During the progress of the disease the urine always becomes highly acrid, so that the bladder can hardly tolerate its presence, even for a few minutes. It generally emits an ammoniacal odor, is of a dirty, turbid, or blackish color, is rapidly decomposed, both in and out the bladder, and is nearly always mixed with epithelial, fibrinous, purulent and phosphatic matter. If a silver catheter is used late in the disease, it usually comes out of a bronze, brownish, or black color, owing to the presence of a minute quantity of sulphuretted hydrogen. Renal casts are nearly always present when there is serious involvement of the kidneys.

The pus in cystorrhœa may proceed from various sources, as the bladder, ureters, prostate gland, and even the kidneys, which are often sadly involved in the mischief. Its presence is always to be regarded with great attention, as it is commonly indicative of serious disease of the organs from which it is derived. The urine is voided frequently, in small quantity, and with more or less difficulty. Generally it passes off in interrupted jets, in a small, feeble stream, or in drops, accompanied by violent spasm and straining. When it is loaded with thick, ropy mucus, the difficulty is much increased, and the patient is obliged to have frequent recourse to the catheter.

The discharge which accompanies this disorder might possibly be confounded with a discharge of semen; but this can only happen when this fluid flows into the

bladder, and mixes with the urine, as in stricture of the urethra, or enlargement of the prostate gland. The distinction is that, in catarrh, the discharge is always greater and more constant, as well as more ropy, tenacious, and offensive, the local suffering is more severe, and there is a more frequent desire to micturate. In spermatorrhœa, the matter is voided in small quantity, and at remote intervals; it has a peculiar odor, is of a light color, and is partially insoluble in water, in which it floats in shreds. If any doubt exist it will readily be solved by the microscope.

The prognosis in cystorrhœa varies with many circumstances which hardly admit of precise detail. Much will necessarily depend upon the age and constitution of the patient, the duration of the disease, and the condition of the bladder and of the associated organs. In its incipient stages it is sometimes not difficult of cure; but when, commencing gradually, it has at length come to disorder the whole system, the issue is rarely favorable.

Fig. 497.



Columniform Bladder.

The morbid alterations are variable. In the early stage, and in the milder forms of the disease, the mucous membrane usually presents slight marks of inflammation,

Fig. 498.



Section of the Bladder and Prostate. *a.* Mucous Surface of the Bladder. *b, b.* Lateral Lobes of the Prostate. *c.* Middle Lobe. *d.* Large Cyst or Pouch, partially laid open, and communicating with the Bladder by a small Orifice.

with little or no lesion of the other tunics. After some time, however, the muscular fibres become hypertrophied, and exhibit the peculiar retiform arrangement delineated in fig. 497, from a specimen in my collection. Occasionally a large bar-like ridge lies immediately behind the neck of the bladder, offering a considerable obstacle to the passage of the catheter.

The fibrous lamella is also much thickened, as well as increased in density, and the mucous membrane, particularly the portion which corresponds with the bas-fond of the organ, is often thrown into large, heavy ridges. In some instances the lining membrane is ulcerated, incrustated with lymph, or protruded across the muscular fibres, in the form of one or more pouches. The walls of the bladder are frequently from five to ten times the natural thickness. The kidneys, ureters, and

prostate gland are generally implicated in the mischief; sometimes to a fatal extent.

The sacculated appearance of the bladder, so frequent an accompaniment of chronic inflammation, is well shown in fig. 498, from a preparation in my private cabinet. It is formed by a projection of the mucous coat across the hypertrophied muscular fibres, and varies in size, from a pigeon's egg to a cavity nearly as large as the bladder itself. It always contains urine, and, occasionally, also calculi. In a case of sacculated bladder, in a man eighty-four years old, reported by Professor W. W. Greene, the adventitious pouch contained nearly one gallon of limpid urine, and was so large as to encroach very seriously upon the abdominal viscera.

Treatment.—In the treatment of this affection, it is of great importance to ascertain the nature of the exciting cause. If this be a stricture of the urethra, stone in the bladder, hypertrophy of the prostate gland, or disease of the neighboring and associated organs, no permanent relief can reasonably be expected until these affections are removed.

Antiphlogistics are imperatively demanded in all cases attended with violent pain and frequent micturition, even when there is no marked constitutional disturbance. When the lancet is inadmissible, from twenty to thirty leeches may be applied to the perineum, the inside of the thighs, and the lower part of the hypogastric region. The topical bleeding should be followed up with a warm bath, fomentations, and warm enemas. The bowels must be opened with saline cathartics, or, when the secretions are much deranged, with calomel and jalap. All articles tending to irritate the rectum should be carefully avoided. The most perfect quietude, both of mind and body, must be enjoined; the diet should be as light and bland as possible, and free use should be made of demulcent drinks, as gum Arabic water, flaxseed tea, or slippery-elm water.

When, by these means, the violence of the disease has been subdued, there is no remedy equal to the balsam of copaiba. It should be given in doses not exceeding ten, twelve, or fifteen drops, three or four times in the twenty-four hours. The best form is that of emulsion. Its nauseating, griping, and purging tendencies should be counteracted by morphia. When the patient is teased with pyrosis or acid eructations, the medicine may advantageously be conjoined with bicarbonate of soda, or soda and potassa.

The terebinthinate preparations are sometimes useful. Pareira brava and buchu have also been much extolled, although very unjustly, as they are generally quite inert. Uva ursi has a specific tendency to the urinary organs, and is particularly serviceable in chronic inflammation attended with excessive morbid sensibility of the neck of the bladder. It may advantageously be conjoined with lupuline, and, in the class of cases just mentioned, with bicarbonate of soda and potassa.

A combination of some of these articles is often beneficial. Indeed, the effect is usually much more conspicuous when thus given than when they are used separately. I have long been in the habit of administering, with the happiest effect, a combination of buchu, uva ursi, and cubebs, sometimes in the form of infusion, but more generally in that of tincture, several times a day, in conjunction with a small quantity of bicarbonate of soda. Occasionally, a few drops of balsam of copaiba, tincture of chloride of iron, or dilute nitric acid, may advantageously be added to each dose of these medicines. The iron, given by itself, sometimes answers an excellent purpose, especially when there is flatulence with indigestion and anemia. When the disease is associated with a gouty or rheumatic state of the system, colchicum is proper, in union with a full anodyne at bedtime. Benzoic acid sometimes affords relief when everything else fails. It should be given in pill form in doses of five to ten grains thrice a day.

In all cases of vesical catarrh, the urine should be subjected to the usual tests. If it be found to be acid, carbonated alkalies should be freely exhibited, and acids if it be alkaline.

To allay pain and induce sleep, anodynes are indispensable in almost every stage of the disease. They should be given in full doses, alone or with other medicines, either hypodermically, by the mouth, or by the rectum. Dover's powder is generally well borne by the stomach, and rarely fails to be productive of benefit. The dose should seldom be less than fifteen grains. It is particularly valuable when there is unusual dryness of the skin.

Counter-irritation, by issue, seton, or tartar emetic pustulation, is often highly

efficacious, especially in obstinate cases. Blisters, except at the commencement of the complaint, or when there is a sudden aggravation of the discharge, seldom afford much relief. Indeed, it is doubtful whether their beneficial effects are not fully counterbalanced by the injurious impression which they sometimes make upon the neck of the bladder, leading to an increase of the local suffering. An emollient poultice lightly sprinkled with mustard often affords temporary relief, and a similar remark is true of flannel cloths wrung out of hot water and laudanum.

The remedies addressed directly to the suffering organ itself are irrigations, astringent and other injections, and cauterization.

Irrigation of the bladder is, in many cases, a valuable auxiliary to the other means already pointed out. It is particularly serviceable when there is an abundant discharge of thick, tenacious mucus, attended with atony of the muscular fibres of the bladder. The operation is performed, with the greatest possible gentleness, with tepid water, injected with a four-ounce gum syringe through a double catheter, care being taken not to permit any air to enter, as it would inevitably cause severe pain. In the absence of a double catheter, an ordinary gum-elastic instrument may be used; but, in such an event, only about an ounce of fluid should be passed in at a time, the operation being repeated until the organ has been thoroughly washed out. Unless this precaution be adopted the operation will be sure to occasion great distress, if not positive mischief, from sudden overdistention of the viscus.

Fluids of various kinds, astringent, anodyne, and alterant, are sometimes introduced into the bladder, for the purpose of making a direct impression upon the inflamed surface. The articles most commonly used are alum, zinc, copper, iodine, nitrate of silver, creasote, opium, morphia, laudanum, cicuta, bichloride of mercury, and nitric, hydrochloric, and carbolic acid.

Whatever the substance may be, a cardinal rule is to throw it in, at first, in as dilute a state as possible. As the affected surface becomes more tolerant, the strength may gradually be increased and the retention more prolonged. For want of this precaution great injury is often inflicted, and a remedy, otherwise calculated to be beneficial, brought into disrepute. The article which, on the whole, I have myself found most efficacious is nitrate of silver, in the proportion of one-fourth, one-third, or one-half a grain to the ounce of tepid water, in union with one drachm of tincture of opium, the bladder having previously been well emptied and washed out, especially when the *bas-fond* is filled with putrid pus and mucus. The fluid should be retained until it causes pain, uneasy sensations, or a feeling of distention, when it should promptly be evacuated. I have never employed strong injections of nitrate of silver in this disease, as from twenty to thirty grains to the ounce of water, as advocated by some, having always been afraid of the result of such heroic practice. Indeed, several cases have been reported to me, in which the effects were so violent as to cause serious apprehension for the ultimate safety of the patient, the great danger being from shock and peritonitis.

Cauterization with solid nitrate of silver is occasionally practised. I have tried it in a number of instances, but without any decided benefit. It is chiefly applicable to those cases in which the catarrh is dependent upon inflammation of the neck of the bladder, and should be employed with the greatest possible caution, lest it aggravate the morbid action.

In obstinate cases, when all other means have failed, it has been suggested to open the neck of the bladder in the same manner as in the lateral operation of lithotomy, to afford a free outlet to the mucus and pus as fast as they form, and to place the organ thereby in a state of repose. The proposal is plausible; and, although it has not been sufficiently tested to enable us to form a definite opinion in regard to its value, it is worthy of a fair trial, as it holds out the only chance of relief.

The diet must be of a light, farinaceous character. Between the paroxysms, or when convalescence is fairly established, animal broths, fresh fish, oysters, and a little of the lighter kinds of meat, may be used. But neither at this nor at any previous period are condiments admissible. Even salt should be very sparingly employed. Vegetable acids, subacid fruits, wine, spirits, and fermented liquors are prejudicial. The best drink is cold water, either alone or with good Holland gin. Sometimes great benefit arises from the steady use of Vichy water.

Exposure to cold must be carefully avoided. Flannel is worn next the skin, both

summer and winter; riding on horseback is interdicted; sexual intercourse is abstained from; and the bladder, for a long time, is emptied daily at stated intervals.

When the kidneys, ureters, and prostate gland are seriously affected, no remedy has the power of checking this distressing malady. All that can be done is to enjoin perfect tranquility, a light but generous diet, anodynes by the mouth, rectum, or hypodermically, the warm bath, and attention to the bowels.

IRRITABILITY OR MORBID SENSIBILITY.

The characteristic symptom of this disease is frequent micturition. The urine is voided every few hours, perhaps, indeed, every few minutes, and the process is commonly attended with more or less pain, spasm, and burning at the neck of the bladder and along the urethra. The fluid may be perfectly natural, both in its physical and chemical properties; or it may be increased or diminished in quantity, and variously altered in quality. In general, it is acid, high-colored, and surcharged with mucus, of a whitish or grayish aspect. The urethra and the prostate gland are usually unnaturally sensitive to the touch, and a very common accompaniment of the affection, especially in young men, is a tendency to erections and seminal discharges. In time, the general health, perhaps originally good, gradually suffers. The disease is most frequently met with in children and youths of a nervous, irritable disposition. It is also sufficiently common in persons who are predisposed to attacks of gout and rheumatism.

Irritability of the bladder may be arranged under different heads, according to the causes by which it is induced, as—1st. Disease of the urinary apparatus. 2d. Altered state of the urine. 3d. Diuretic medicines. 4th. Disorder of the genital organs. 5th. Derangement of the alimentary canal. 6th. Lesion of the brain and spinal cord. 7th. General debility. 8th. Exposure to cold and heat. 9th. Disease of the pelvic viscera. In hemorrhoids, fistules, epithelioma, and polyps of the rectum, the bladder is always more or less irritable; sometimes, indeed, exquisitely so.

The pathology of this disease is not well understood. The most plausible conclusion, perhaps, is that the complaint consists in an exaltation of the nervous sensibility of the mucous membrane, similar to that occasionally witnessed in the eye, fauces, urethra, and other mucous canals. When the disease depends upon local causes, as stone in the bladder, stricture of the urethra, or enlargement of the prostate gland, the anatomical changes are more distinct, and afford a more satisfactory solution of the true nature of the case. Very frequently the irritability is purely sympathetic.

The prognosis is variable. The idiopathic form of the complaint, although frequently very obstinate, generally, after a time, yields to a well-directed course of treatment. When the disease occurs in weak, scrofulous subjects, it is always remarkably refractory. The irritability of the bladder of young children, attended with nocturnal incontinence of urine, sometimes disappears spontaneously towards the approach of puberty. When dependent upon local causes, of a curable nature, relief may generally be obtained.

In the *treatment* of this complaint, so Protean in its character, a strict inquiry should, in every instance, be instituted into its origin, and the practice be regulated accordingly. When the irritability depends upon congestion or inflammation, the application of leeches to the perineum, the hip-bath, and, in plethoric subjects, venesection, are indicated. Laxatives, rest, low diet, the internal use of balsam of copaiba, and anodyne injections, should not be neglected. If the disorder depend upon an acid state of the urine, alkalies will be indicated, and the one which I usually prefer is bicarbonate of soda, either alone or in union with potassa. Colchicum will be useful, especially if given in combination with morphia and spirit of nitrous ether, when the patient is of a rheumatic or gouty habit. The best form of exhibition is the wine, in the dose of one drachm every night at bedtime. When the disease has been induced by the improper employment of diuretics, a discontinuance of the remedies, and the liberal use of diluents, the hip-bath, hot fomentations, and a full anodyne by the mouth or rectum, will, in general, speedily arrest it.

All venereal excesses must be abandoned, and means taken to remove the disastrous effects thereby produced. Of these, the most important are quinine and the chalybeate tonics, blue mass and rhubarb as a purgative, light but generous alimen-

tation, cold ablutions, the cold shower-bath, and exercise in the open air. If spermatorrhœa be present, nothing short of cauterization will be likely to answer. In this form of irritability of the bladder, good effects sometimes result from the exhibition of bromide of potassium, in doses of twenty to thirty grains thrice in the twenty-four hours.

When the irritation is due to disorder of the digestive organs, particular attention must be paid to the correction of the secretions; the diet should be carefully regulated, and the bowels should, from time to time, be duly evacuated. If symptoms of worms be present, anthelmintics are indicated, of which calomel, spirit of turpentine, and chenopodium are the most valuable. In those forms of the complaint which are dependent upon piles, ulcers, fistule, and other organic changes of the rectum and anus, there can, of course, be no hope of relief without striking at the root of the evil. Tumors must be removed, ulcers cauterized or incised, and sinuses laid open.

Mere distention of the rectum by gas and fecal matter is a common cause of vesical irritability, leading to a frequent desire to void the urine. Such cases, of course, suggest their own treatment.

Of late years, carbonic acid gas has been a good deal employed as a local sedative in this complaint, and there is no doubt that it occasionally exerts a very happy influence in relieving pain and checking the disposition to frequent micturition, the effect being sometimes more anodyne than that of strong opiates, while it is destitute of the disagreeable consequences which so often follow the exhibition of the latter articles.

Irritability of the bladder, dependent upon lesion of the brain and spinal cord, must be treated upon general principles, the bromides, chloral, and opiates being among the more valuable therapeutic agents.

In the vesical irritability which is so common in young girls, at or soon after the age of puberty, and which is probably of a mixed character, depending partly upon spinal irritation, and partly upon disorder of the uterine functions, much benefit will be derived from a proper regulation of the bowels, chalybeate tonics, particularly Griffith's mixture, Plummer's pills, the shower-bath, and daily exercise in the open air. In protracted cases, the uterus should be examined, as the cause may depend upon displacement of that organ.

In the vesical irritability known as strangury, caused by the absorption of cantharidine, prompt relief is generally afforded by a full enema of laudanum, assisted by the administration of spirit of camphor, in doses of fifteen to twenty drops, repeated every half hour, and by hot cloths applied to the genitals and hypogastrium. A third of a grain of morphia used hypodermically often acts like a charm.

When the disease has been induced by general debility, an invigorating diet, nutritious drinks, and tonics, especially quinine, bark, and the different preparations of iron, with exercise in the open air, are indicated.

If the disease has been induced by cold, and the patient is robust and plethoric, venesection, carried to syncope, will generally afford prompt relief, especially if it be aided by diaphoretics, as a combination of antimony and morphia, or Dover's powder, brisk cathartics, anodyne injections, and hot fomentations.

The neuralgic form of the disease is best controlled by quinine, strychnia, and arsenic, in union with morphia, aconite, or belladonna. Sometimes the wine of colchicum proves highly efficacious.

In most of the varieties of morbid sensibility of the bladder here described, there are few articles of the materia medica which afford such prompt relief, after removal of the exciting cause, as belladonna, administered either by itself or in union with some of the remedies above specified. The best form of exhibition, according to my experience, is the juice, in doses of about five drops, repeated three or four times in the twenty-four hours. Sometimes the medicine may be advantageously introduced into the bladder, injected under the skin, or thrown into the bowel in the form of enema.

Another remedy, worthy of trial in such cases, is the bromide of ammonium, in doses of twenty to thirty grains, in a suitable quantity of water, from half an hour to an hour after each meal. Its efficacy will be materially enhanced if it be combined with chloral.

NEURALGIA.

Neuralgia of the bladder is a nervous affection, characterized by violent suffering, which is generally referred to, and most severe at, the neck and bas-fond of the organ. It presents itself in two varieties of form, in one of which, the more common, the suffering is more or less steady and persistent, often remitting, but seldom intermitting; in the other, it is distinctly paroxysmal, recurring daily or every other day, about the same period, usually early in the evening or towards morning. The pain, which is often of the most racking, agonizing nature, is reflected to the neighboring parts, and is accompanied with a sensation of heat and burning in the urethra, with a frequent desire to pass water, the urine being thrown out in jets, or in a small, tiny stream. The attack gradually goes off, leaving no other inconvenience than a feeling of soreness or aching in the neck of the bladder, perineum, and posterior part of the urethra. The general health eventually becomes affected. In obstinate cases, there is a thin, gleety discharge, with great soreness in the perineum and hypogastric region. The urine is commonly natural. The diagnosis is not always very clear. The attacks, especially when very severe, bear the closest resemblance to the paroxysms produced by a calculus. Hence, in doubtful cases, sounding of the bladder is advisable.

The causes of vesical neuralgia are often wholly inappreciable. The disease is most common in persons of a nervous temperament. Venereal excesses, masturbation, stricture of the urethra, disorder of the prostate gland, stone in the bladder, and organic disease of the kidneys, uterus, anus, and rectum, are all capable of producing it. What influence miasm may exert upon its development is not ascertained, but it is, doubtless, a very frequent cause of the complaint. The disease, although exceedingly painful and distressing, seldom terminates fatally. Its long continuance, however, or its frequent recurrence, may render the patient miserable for life.

The *treatment* must be regulated by the nature of the exciting cause. When it is connected with an inflammatory state of the system, prompt and efficient bloodletting is the proper remedy, especially at the commencement of the attack. Purgatives are particularly useful when the affection is associated with derangement of the digestive apparatus. If the tongue is much coated, the best article will be calomel, followed by castor oil. After this, a blue pill, given every other night, will serve to keep the bowels in a soluble condition. When the disease is plainly of a miasmatic character, the most suitable remedy is quinine, either alone or in union with arsenic, strychnia, aconite, and morphia. During the violence of the paroxysm, large doses of narcotics are frequently indispensable. Of these, the most efficacious are the salts of morphia, either alone or combined with nauseants and tincture of aconite, according to the state of the vascular system. An emetic of ipecacuanha at the approach of the attack will sometimes cut it short. Much benefit will also accrue, in many cases, from the use of the warm bath. In persons of a gouty, rheumatic habit, no remedy will be so likely to be successful as colchicum. In the more aggravated and intractable varieties of the malady, counter-irritation over the perineum, the supra-pubic region, the sacrum, or the inner part of the thighs, is worthy of trial. The best forms are the moxa and the caustic issue. When the neuralgia depends upon stricture of the urethra, foreign bodies in the bladder, hemorrhoids, fissure, or some other disease of the anus, none but the most transient amelioration can be expected from any mode of treatment, until the exciting cause has been removed.

The strictest attention should be paid to the diet. Everything tending to disorder the digestive apparatus, and induce acidity and flatulence, should be avoided. Dyspepsia should be relieved by tonics, as iron and quinine. Occasionally, great relief follows the use of large doses of subnitrate of bismuth, taken an hour after each meal. Exposure to cold is avoided; flannel is worn next the surface; and sexual intercourse is prohibited.

GOUT AND RHEUMATISM.

The bladder, like the stomach, bowels, heart, kidneys, and other organs, is liable to gout and rheumatism, either as original and independent affections, or, as is more frequently the case, as consequences of the translation of these diseases from some other structures. Thus, it is not uncommon for a person who has gout or rheumatism of the foot or knee to be seized during the progress of the attack with gout or

rheumatism of the bladder. Occasionally, the vesical malady comes on so suddenly, and at a time, perhaps, when such a degree of relief is experienced in the part originally involved, as to leave no doubt that the attack consists merely in a transfer of morbid action from one place to another.

Although these affections may occur at any period of life, indeed, even in very young children, they are most common in elderly subjects, especially in males who have long been addicted to all kinds of excesses in eating and drinking, and whose constitution has been still further impaired by repeated attacks of gout and rheumatism in other parts of the body. Women suffer less frequently than men, simply, perhaps, because they are not so often exposed to the exciting causes of these diseases.

An attack of vesical gout or rheumatism is generally brought on under the influence of cold, disorder of the digestive organs, overstimulation, want of exercise, or venereal excesses. Occasionally it is provoked by stricture of the urethra, enlargement of the prostate gland, disease of the kidneys, the presence of a vesical calculus, or an acrid state of the urine. It may also be induced by organic affections of the uterus, vagina, anus, and rectum.

The symptoms are very similar to those of neuralgia. The bladder is not only excessively irritable, with a constant inclination to expel its contents, but more or less painful and tender on pressure. The suffering is most severe in the pelvic region, from which, however, it radiates about in different directions, especially into the lumbar region, in the course of the spermatic cords, down the thighs, and around the anus and perineum. Occasionally a good deal of fever is present, but cases occur in which there is not the slightest arterial excitement or other evidence of pyrexia. The tongue, however, is generally considerably coated, the appetite is impaired, and the bowels are constipated. Marked alteration always exists in the urine. Most commonly the fluid is very scanty, of high specific gravity, and of a smoky aspect, from the presence of lithic acid, renal casts, and a redundancy of mucus. In some cases, the secretion, instead of being acid, is highly alkaline, ropy, putrescent, albuminous, or even purulent. When the muscular coat of the bladder is seriously involved in the disease, retention of urine is apt to occur.

The diagnosis of these diseases is sometimes very difficult. The affections with which they are most liable to be confounded are neuralgia and spasm of the bladder, however induced. The most important signs of distinction are the mode of the attack, and the presence or absence of similar suffering in other parts of the body. If the vesical seizure occurs coincidently with an attack of gout or rheumatism in a joint, it may fairly be assumed that it is of a similar character, and this conclusion will be greatly strengthened if, soon after the vesical seizure, the articular one is either very much relieved, or completely dispelled. In doubtful cases, a careful examination should be made of the urine. Much difficulty will often be experienced in distinguishing between gout and rheumatism of the bladder, although, practically speaking, this is really a matter of very little moment. It should be borne in mind, also, that the symptoms of these diseases are sometimes closely simulated by stone in the bladder.

The prognosis is generally favorable. The vesical disease may, it is true, last, with various intermissions, for a long time, but, in the end, it will usually be found to be amenable to judicious medication.

In the *treatment* of these affections, so closely allied in their nature and origin, the principal reliance must, in the first instance, be upon purgatives, to relieve the bowels, and correct the secretions, and afterwards upon colchicum, aided by anodynes and alkalies. When the violence of the attack has thus been considerably abated, great benefit will generally accrue from the steady use of Dover's powder, opiate suppositories, and mild sinapisms to the hypogastrium and sacrolumbar region. If the patient is robust and plethoric, blood may advantageously be taken from the arm, while, if the reverse be the case, tonics and stimulants will be indicated. The diet must, of course, be properly regulated, and all sources of excitement carefully avoided. If the attack is very rebellious, a large blister, applied to the lower part of the spine, will be useful.

PARALYSIS.

Paralysis of the bladder may arise from various causes, some of which are seated in the organ itself, others in the cerebro-spinal axis, and others, apparently, in the mind. Thus, the organ is often palsied by external injury, as a blow or kick upon the hypogastrium, or the pressure of the child's head in parturition; inflammation of its different tunics; or overdistention of its muscular fibres from protracted retention of urine. Compression of the brain and spinal cord is always followed by loss of power of this organ. Want of tone in the general system may induce the disease, as is so often witnessed during the progress of encephalitis, apoplexy, and fever, especially typhoid. The bladder first loses its sensibility, and then the urine, ceasing to make its accustomed impression, continues to accumulate, without awakening any desire to evacuate it, until the muscular fibres are so completely overstretched as to render them incapable of contracting.

Severe injuries, amputations, the ligation of hemorrhoidal tumors, and various other operations are liable to be followed by transient paralysis of this organ. Lying-in females are often unable to pass urine for several days after delivery.

Hysterical women are sometimes unable to void their urine, owing, apparently, to paralysis of the bladder, but in reality to a want of mental power to excite the muscles of the organ.

Senile paralysis of this organ, as it is termed, is most common in elderly, indolent men, who indulge too freely in the pleasures of the table, and who habitually neglect the calls of nature. The paralysis usually comes on in a slow, stealthy manner. One of the first symptoms which attract attention is a slight difficulty in starting the urine. As the disease advances, the muscular contractility is still further impaired; and the water, instead of being ejected in a bold, full stream, falls between the patient's legs or upon his shoes.

As soon as the bladder has lost its power of contraction, its contents accumulate and distend its walls. The organ gradually rises above the pubes, forming a tumor which sometimes reaches as high as the umbilicus, and as far outwards as the brim of the pelvis. The swelling is of an ovoidal shape, fluctuating, indolent at first, but painful afterwards, and attended with complete retention, which constitutes one of the characteristic symptoms of the disease. The duration of the paralysis varies from a few hours to several weeks, months, or even years. Occasionally it ceases only with life. When the paralysis is produced by injury of the spinal cord, the urine is usually highly alkaline, very dark or turbid, of an ammoniacal odor, and surcharged with thick, ropy mucus. Phosphatic matter soon makes its appearance, and the lining membrane speedily becomes inflamed, if not ulcerated, followed by a discharge of blood and pus. Persons thus affected are very liable to calculous diseases.

The prognosis of vesical paralysis depends upon the nature of its causes, the character of the treatment, and the age of the patient. If the bladder has been very greatly and protractedly distended, it will necessarily be a long time, if ever, before it can regain its full vigor.

The *treatment* of an affection depending upon so many and such opposite causes must necessarily be of a very diversified character. The urine, as a general rule, should be drawn off at least three times a day. Occasionally the catheter may be constantly retained, especially when there are pain and spasm of the neck of the bladder, with a frequent desire to pass water. When the accumulation is very great, and has continued for several days, the best plan is not to evacuate all the fluid at once. The use of the instrument is discontinued as soon as the organ has regained its expulsive power.

To impart tone to the bladder, another important indication, various remedies may be used. A brisk cathartic, consisting of calomel and jalap, or of calomel and compound extract of colocynth, often produces the most prompt and happy effect, and should be employed as soon as possible after the organ has been relieved of its burden. The medicine may be repeated, in small doses, at first every other day, and afterwards twice a week.

Emetics are sometimes of signal benefit. They are particularly valuable when the paralysis is coincident with disorder of the digestive organs, and torpor of the general system. They are of course contra-indicated in the traumatic form of the disease.

After the bowels have been well evacuated, and the secretions restored, remedies calculated to make a more direct impression upon the nervous system are employed, strychnia, cantharides, and arnica occupying the head of the list. An excellent formula, when they are given in combination, is the sixteenth of a grain of strychnia, half that quantity of cantharides, and from three to five grains of extract of arnica, three times in the twenty-four hours, care being taken to watch the effect. If spasmodic twitchings, strangury, or gastric irritability ensue, it is an evidence that they have been carried far enough, or that some modification is required. In paralysis of the bladder, consequent upon typhoid and other fevers, masturbation, and general exhaustion, few remedies are so serviceable as arnica.

Strong testimony has repeatedly been published in favor of the use of ergot of rye in the treatment of this affection, and of its efficacy I can speak strongly from personal experience. The dose usually given, in the twenty-four hours, is from one to two scruples of the recent powder. The best form of administration, perhaps, is a very strong tincture, prepared with six ounces of the substance to a pint of rectified spirit, the dose being a drachm three times a day, in an effervescing draught of citrate of ammonia. The fluid extract is also a convenient mode of administration.

In the inflammatory form of the disease, characterized by pain and spasm of the neck of the bladder, with a constant desire to urinate, and more or less febrile commotion, the treatment must be strictly antiphlogistic and anodyne. When general debility exists, tonics are indicated, preference being commonly given to the chalybeate preparations, combined, if necessary with quinine, strychnia, arnica, and other articles.

In hysterical paralysis, the mind is affected rather than the bladder. The want of power is, no doubt, sometimes real, but oftener it is feigned. Such cases are always promptly relieved by assafoetida, valerian, and morphia, aided by the catheter. These remedies, however, are merely palliative. To effect a permanent cure, the treatment should be directed to the improvement of the mind and of the general health rather than of the condition of the bladder.

Counter-irritation is a useful auxiliary to the other remedies. A succession of blisters over the dorsolumbar region often proves highly beneficial, by stimulating the spinal cord. The vesicated surface may be sprinkled every twelve hours, over a space of about the size of a dollar, with half a grain of strychnia.

The actual cautery is a most powerful and suitable agent, especially in the more rebellious forms of vesical paralysis. The best place for applying it is about the junction of the last lumbar vertebra with the sacrum; in traumatic cases, however, depending upon injury of the spine, the issue should sometimes be made much higher up. The instrument employed for this object should be fully one inch in diameter; and a free discharge should, if necessary, be maintained for several consecutive months.

Counter-irritation by seton is hardly ever to be recommended. Frictions over the perineum and hypogastrium with veratria ointment and stimulating embrocations, as turpentine and ammonia, are sometimes serviceable. The cold douche is a remedy of great potency in many cases of this disease. It is a most powerful stimulant, and sometimes rouses the dormant energies of the bladder when almost everything else has failed. Galvanism is particularly indicated in senile palsy, attended with partial paraplegia.

No very satisfactory observations have yet been made in regard to direct medication in the treatment of vesical paralysis. Paul, of Ægineta, and some modern practitioners have advised astringent injections; and Deschamps states that he has effected cures with cold water thus employed. In a very obstinate case, resisting every known method of treatment, both general and local, for ten weeks, relief was speedily effected by injections of strychnia. The proper dose of the article, when thus administered, is from one-sixth to one-fourth of a grain, dissolved in two ounces of tepid water, and repeated every twenty-four hours.

HEMORRHAGE.

A discharge of blood from the bladder, technically denominated hematuria, although not of frequent occurrence, is generally a source of disquietude to the patient, from a belief, not altogether unfounded, that it is a symptom of evil import. The bleeding occurs in both sexes, and at all periods of life. Men, however, are more

liable to it than women; and it is likewise more common in old and middle-aged subjects than in children and adolescents.

Vesical hemorrhage presents itself under two varieties of form, the idiopathic and traumatic. The former, which is infrequent, is met with chiefly in elderly persons of a weak, lax habit of body, or in such as are affected with scurvy, or anemia. It sometimes occurs in association with, or as a sequence of, rubeola, smallpox, plague, and typhoid fever. The traumatic form is usually the result of a wound of the bladder, or of the rude and forcible use of instruments.

Persons affected with stone are very liable to suffer from hematuria, especially after any rough exercise. Worms in the bladder have been known to occasion profuse and even fatal hemorrhage. Violent concussion of the body, severe exercise on horseback, and venereal excesses, may be enumerated as among the more common causes.

A considerable hemorrhage of the bladder occasionally results from the use of drastic cathartics and irritating diuretics. Ulceration of the mucous and submucous cellular tissues is nearly always accompanied by bleeding, and one of the most characteristic signs of papillary, encephaloid, and erectile tumors, is a considerable flow of blood. Finally, vesical hemorrhage is sometimes vicarious of the menstrual flux, and of suppressed hemorrhoidal discharges. It also, although rarely, marks the crisis of other diseases.

When recently effused into the empty bladder, the blood is of a natural appearance; if on the contrary, it has been retained for some time, or mixed with the urine, it will be found to be of a dark-brownish, turbid, or smoky hue. In its consistence, the blood may be liquid, semifluid, or completely solid.

The symptoms of vesical hemorrhage are a discharge of blood from the urethra, either alone or in combination with urine, and accompanied, if the quantity is at all considerable, by a frequent desire to micturate, spasm at the neck of the bladder, and a burning sensation along the course of the urethra. When the blood coagulates nearly as fast as it is poured out by the bladder, it may lead to retention of the urine. Copious effusions of this kind may eventually be followed by all the symptoms of exhaustion.

As hemorrhage of the bladder is liable to be mistaken for hemorrhage of the kidneys, ureters, prostate gland, and urethra, the diagnosis is sometimes extremely difficult, if not impracticable. In case of direct injury of the bladder, there need be no doubt. In the idiopathic form of the hemorrhage, however, great uncertainty must frequently exist. In such an event, the history of the case, and the absence of disease or injury of the associated organs, may assist the diagnosis. In renal hemorrhage, the disruption is usually dependent upon injury or structural lesion of the kidneys, and is, therefore, generally preceded and accompanied by symptoms referable to these organs. The blood is of a pale, pink, or claret complexion, and either entirely fluid, or partly fluid and partly coagulated; it is never voided in a pure state, as it often is when it proceeds from the bladder, prostate gland, or urethra. The microscope also readily detects blood casts, consisting of blood moulded in the uriniferous tubes, and washed out by the urine. Moreover, the epithelium which accompanies it does not occur in flat scales, as when it comes from the bladder, but in small, spherical particles. Sometimes the blood is voided in whitish, cylindrical clots, but, unless they are united with renal casts, they are of no diagnostic value. When the bleeding proceeds from the ureters, it is usually due to the presence of a calculus, which gives rise to the symptoms associated with the passage of concretions along these conduits.

Hemorrhage of the urethra is generally produced by external violence, the passage of a calculus, or the venereal orgasm, and the blood commonly passes off in small vermiform pieces, without any material change of color, or any desire to void the urine. In many cases, the blood is discharged in drops, or in a small stream.

In the traumatic variety of hemorrhage, the ordinary hemostatics are, of course, indicated, and should be employed without delay. Accessible arteries are exposed and tied, or, when this is impracticable, compression and cold applications are used. All offending causes are sought for, and, if possible, removed. When the bleeding proceeds from an encephaloid, papillary, or erectile tumor, palliation alone is attempted. In such cases, the main reliance is upon opium and lead, gallic acid, alum, and perchloride of iron, with acidulated drinks, rest in the recumbent posture, and cold applications to the perineum and hypogastrium. The catheter should be avoided.

In vesical hemorrhage dependent upon papillary excrescences of the bladder, I have often succeeded in affording prompt relief by a good dose of calomel and rhubarb, followed by alum and opium, with sulphuric acid and infusion of roses as a common drink.

In idiopathic hemorrhage of the bladder, great attention must be paid to the system. Vascular action is reduced, the bowels and secretions are carefully regulated, the diet must be light and unstimulating, and the drinks should be cooling and acidulated. Absolute rest in the recumbent posture is of essential importance. The most useful remedies are gallic acid, acetate of lead, and alum, combined with opium. Tannic acid, elixir of vitriol, and tincture of ergot also prove highly efficacious. In hemorrhage caused by anemia, chalybeate tonics are indicated, the best forms being the tincture of the chloride, the sulphate, and the tannate of iron. In bleeding of the bladder, vicarious of the menstrual flux, emmenagogues and aloetic purgatives are required. In all cases, the action of internal remedies is promoted by refrigerant applications to the perineum, inside of the thighs, and hypogastric region. Cold enemata are also beneficial; and a lump of ice introduced into the rectum sometimes acts like a charm. Leeching and cupping over the sacrum are useful, when pain and spasm exist. Direct medication, by astringent injections, occasionally proves serviceable. If the blood coagulates so as to distend the bladder, it may sometimes be removed by injections of cold water, or, what is still better, vinegar and water, after the clot has been broken up with a silver catheter.

When all other means fail, and the symptoms are so urgent as not to admit of further delay, the only resource is to open the bladder, as in the operation of lithotomy. When practicable, the lateral method should be performed, and the clotted blood removed with the scoop.

TUMORS OR MORBID GROWTHS.

1. *Benign Tumors.*—The bladder is liable to *polyps*, of a gelatinoid, fibrous, or vascular nature, occurring chiefly in young subjects; sometimes, indeed, within less than two years after birth. An instructive paper, detailing the particulars of ten cases, including one seen by himself, has been published by Mr. Birkett, of London. The growth described by this distinguished surgeon was attached to the upper boundary of the neck of the bladder, from which it projected forwards into the urinary meatus. It was composed of lobes and lobules, was of a soft, friable consistence, not unlike certain nasal polyps, and was covered with epithelium, but was not very vascular. The patient was a girl five years of age.

The late Dr. C. S. Bishop kindly communicated to me the particulars of the case of a lady, fifty-six years of age, from whose bladder he removed, by means of a double canula, a cylindrical, vascular polyp, nearly three inches in length. It had a globular head eight lines in diameter, and was attached by a narrow pedicle to the *bas-fond* of the organ. Finding, at one of his visits, a portion of it projecting at the orifice of the urethra, he at once ligated it; and next day, after having satisfied himself of its precise situation by making traction upon the ligature while the index finger rested in the vagina, he dextrously slipped a wire around its neck. At the expiration of forty-eight hours, he removed the mass by rotating the canula upon its axis. The principal symptoms were, frequent micturition, bloody urine, excessive pain, and sudden stoppage of water, as if the mouth of the urethra had been closed by a valve.

Various anomalous growths, known by the terms *fatty* and *steatomatous*, are sometimes observed in the bladder, but their occurrence is so uncommon that it is scarcely necessary to allude to, much less describe, them. They seldom attain a large bulk, are generally situated in the *bas-fond* of the organ, and always exhibit the same structure as in other parts of the body.

The *papillary* tumor of the bladder is also occasionally met with, particularly in the trigone, where it forms a soft, villous growth, similar, in every respect, to papiloma of the rectum. Varying in size from a pea to a pullet's egg, it consists of enormously hypertrophied, dendritic, variously branched, and very vascular villi, which are liable to pour out a considerable quantity of blood, under the influence of acrid urine, ulceration, or instrumental contact. The only evidence of the true nature of the disease is the presence in the urine of detached portions of the mass, which, on minute examination, are found to be devoid of carcinomatous infiltration.

Finally, *erectile* tumors, which are probably nothing more than highly vascular or *nævoid* papillary growths, sometimes occur in this organ. The annexed drawing, fig. 499, taken from a preparation in the pathological collection of the New York Hospital, represents a growth of this description. The specimen was deposited by Dr. Cheeseman, who informed me that the patient, a widow, seventy-two years of age, had been of a spare habit of body, and the mother of five or six children. Although naturally feeble, her general health had always been good until about three years before her death, when she began to complain of uneasiness in her bladder, attended with a frequent inclination to void her urine, which was always mixed with blood. Her symptoms gradually increased in violence; she became pale and anemic, and finally died completely exhausted. For some time before her death, she suffered severely from pain in the bladder during micturition, especially immediately after the passage of the last drops of water. She never experienced any retention, and the blood always came away in a dissolved condition. The tumor, which occupied the floor of the bladder, was of a soft, spongy character, of a florid color, circular in form, and about two inches in diameter. It seemed to spring from the mucous membrane, and had a rough, irregular surface, not unlike that of a cauliflower. The parts around were free from inflammation and other disease; but the muscular tunic was somewhat thickened and reticulated. All the other organs were healthy.



Erectile Tumor of the Bladder.

Of the exciting causes and diagnostic characters of polypoid, papillary, steatomatous, and other tumors of the bladder, nothing, unfortunately, is known. From the constant pains in the pelvic region, with the straining efforts, and the frequent inclination to void the urine, which are almost always present, the existence of stone is apt to be suspected; an apprehension which is not always relieved by sounding, which, however, should never be omitted in cases of a doubtful nature. Whenever their true character can be ascertained, the bladder should be laid open as in the common operation of cystotomy, and their removal effected with a pair of probe-pointed scissors curved on the flat.

2. *Carcinomatous Tumors*.—The bladder is liable to malignant diseases, as epithelioma and encephaloid. Of colloid and melanosis, as occurring in this organ, hardly any cases have been recorded. I have myself seen only one example of the latter, the patient being a man, fifty-eight years of age. The disease, which presented itself in the form of five or six little nodules, coexisted with melanosis in nearly all the principal organs of the body, and did not manifest itself by any signs during life.

A striking feature in many cases of carcinoma of the bladder is the excessive proliferation of the papillary layer of the mucous membrane, giving rise to the so-called "villous carcinoma," a term, however, which should be abolished, as it only leads to confusion. As in ordinary papilloma, the villi are greatly enlarged, but their connective tissue is largely infiltrated with epithelium and cell cylinders, as represented in fig. 500, reduced from Demme, a peculiarity of structure which readily distinguishes carcinomatous from simple hyperplastic formations.

Scirrhus, now known as epithelioma, or epithelial carcinoma, of the bladder, is extremely uncommon.

Fig. 500.



Carcinomatous Vesical Papilla.

It is chiefly observed in men, between the ages of forty-five and sixty, at the neck and base of the viscus. It occasionally coexists with epithelioma or scirrhus in other organs, as the liver, uterus, breast, and prostate gland. During its progress the associated structures are liable to become implicated. In the female epithelioma often occurs as a secondary affection from extension of the disease from the vagina and uterus. In the male the organ occasionally suffers in a similar manner in connection with carcinoma of the rectum.

There are no signs by which epithelioma can be distinguished from other diseases of the bladder. The most reliable evidences are, the peculiar lancinating character of the pain, the progressive emaciation, the wan and sallow state of the countenance, the age of the patient, the excessive burning at the neck of the organ and in the urethra immediately after micturition, and the occasional discharge of small fragments of the heterologous matter. These, if examined with the microscope, will be found to display the usual characteristics of such formations, and will, of course, at once remove all doubt respecting the nature of the disease. Too much reliance, however, must not be placed on the appearances of cells voided with the urine, since the transitional forms of the epithelium lining the genito-urinary tract are so similar to those of carcinoma that the distinction is difficult. When a solid mass, after proper preparation, presents the ordinary minute features of carcinoma, or small shreds, representing enlarged and infiltrated papillæ, can be detected, the diagnosis is unequivocal. Negative testimony is afforded by sounding. No positive conclusion can be drawn from the frequent micturition, the condition of the urine, and the presence of mucus, pus, or puriform fluid.

The suffering in this disease is generally so excessive as to require enormous doses of morphia, both by the mouth and rectum, for its relief. In one of my cases, the pain was more severe than I had ever witnessed in any other affection. Towards the close of the disease, anodynes produced so little effect that the patient, a gentleman, forty-four years of age, was obliged to be kept almost constantly under the influence of chloroform. The dissection revealed ulcerated epithelial disease of the base of the bladder.

Encephaloid of the bladder, likewise known by the name of fungus hematodes, or soft carcinoma, usually runs its course with great rapidity, destroying life in from nine to twelve months. Any portion of the organ may be affected with it, but its most common situation is just behind the neck, between the mouth of the urethra and the outlets of the ureters. It may occur as a solitary tumor, projecting into, and almost filling up, the bladder, or in the form of small nodules, from the volume of a pea up to that of a walnut.

Tumors of this kind are occasionally associated with calculi, which are either partially imbedded in their substance, or else lie loose in the bladder. When of large size, they encroach so much upon the organ as to leave hardly any room for the urine. In most cases of encephaloid, the intermediate substance of the bladder is perfectly healthy; in others, it is diseased and hypertrophied. Sometimes the organ is very much contracted, while at others it is greatly enlarged.

The most characteristic symptoms are, uneasiness about the neck of the bladder, frequent micturition, a bloody state of the urine, a discharge of cerebriform matter, and a peculiar cachectic state of the countenance. When all these phenomena are present, hardly any reasonable doubt can be entertained respecting the nature of the case. Still, as error may possibly arise, the bladder should always be thoroughly explored with the sound. If no calculus be detected, it will be an additional proof of the existence of encephaloid, especially if the operation be followed by considerable hemorrhage. The tumor is often detectable by the finger in the rectum; and a microscopic examination of the suspected matter generally affords useful information.

Mitigation of suffering is all that can be aimed at in this disease. The proper remedies, of course, are anodynes, in full and sustained doses. To check the hemorrhage which always attends the ulcerative stage, it will be necessary to make free use of perchloride of iron and opium, acetate of lead, alum, tannic acid, creasote, ergot, and similar articles. When the discharge is obstinate, or unusually copious, astringents may be thrown into the bladder.

3. *Sarcomatous Tumors*.—The recorded cases of sarcoma of the bladder are so few that any deductions as to their clinical features are impossible. It is, however, highly probable that many neoplasms have been included under polypoid and villous

growths which were composed of sarcomatous tissue. The most interesting example of this nature, with which I am acquainted, has been reported by Dr. Senftleben, from the practice of Professor Langenbeck, as having occurred in a woman, twenty-nine years of age, who had been troubled with difficulty of micturition and dribbling of urine for fifteen months. During forcible efforts to relieve the bladder and rectum, a red, fleshy mass always protruded from the urethra, which she was in the habit of snipping off, as the operation was attended neither with pain nor hemorrhage. Attempts to remove the growth with polyp-forceps were futile, on account of its great friability, and were followed by death, from peritonitis, on the fourth day. Dissection disclosed, immediately below the urethral orifice, a villous mass, of the size of a walnut, which had its origin in the intermuscular connective tissue, and was made up of spindle cells. The base of the bladder had been perforated by the forceps. Dr. Senftleben has collected 15 examples of vesical polyps removed by the knife or ligature, all of which, with one exception, were fatal; and he is, therefore, of the opinion that extirpation by supra-pubic cystotomy is the only proper procedure.

TUBERCULOSIS.

The bladder is sometimes the seat of tubercular disease. The deposit is commonly met with in the form of minute granulations, similar to those which occur in the bowels and lungs. Their number is generally small. It is probable that they may occur in any part of the bladder, but they are by far most common in the neck and bas-fond of the organ.

The seat of this deposit is in the superficial layers of the mucous membrane. After the tubercle has existed for an indefinite period, it begins to soften, and is finally entirely broken down and expelled, leaving, in its stead, a small, roundish ulcer, with thin, ragged, and undermined edges, which are infiltrated with the heterogeneous deposit.

Tuberculosis of the bladder is generally, if not invariably, associated with tuberculosis in other parts of the body, especially the kidney and the prostate gland. Its coexistence with phthisis is uncommon.

There are, unfortunately, no symptoms by which we can, with any certainty, determine the existence of tubercular disease of the bladder. As long as the deposit remains in a state of crudity, there is, in general, merely a slight degree of irritability of the mucous membrane, with increased frequency of micturition. When softening has commenced, the peculiar matter of tubercle is discharged along with the urine, in which it may often be detected with the naked eye. When any doubt exists, a small quantity should be placed under the microscope.

The ulceration attending this disease occasionally spreads over the whole mucous surface, which is gradually removed in as clean and perfect a manner as if it had been dissected off with the knife. Several specimens, illustrative of this condition, are contained in my private collection. When the case has reached this point, the suffering is most excruciating, there being a constant desire to pass water, and the patient being rapidly worn out by the conjoint influence of pain and want of appetite and sleep. Palliation by anodynes, in full and sustained doses, is all that the disease admits of.

CYSTOCELE OR HERNIA.

The bladder, like other viscera, is liable to protrude from the pelvic cavity, constituting what is denominated cystocele. A hernia of this description is sometimes complicated with a bubonocoele or rupture of the groin, which it may either precede or follow. Occasionally the dislocated organ contains a stone.

The cystic hernia is destitute of a proper sac. The only exception to this rule is where the rupture is of long standing, or of great bulk, when the fundus of the bladder may drag the peritoneum down into the scrotum. The swelling is always formed, in great measure, by the superior portion of the viscus, and is, generally, of small size, although, occasionally, it has been known to attain the magnitude of a fist.

A cystocele is a soft, elastic, and fluctuating tumor, which varies in its size according to the amount of urine contained in the protruded part. When examined in a dark room, with the aid of a candle, it appears translucent, very much like a hydrocele.

The diagnosis is a matter of great importance, as a tumor of this kind has occa-

sionally been cut into by mistake. The most decisive symptom is the change which the swelling undergoes in its volume during micturition. As the water flows off, the tumor decreases, or entirely disappears, to recur again, however, as soon as the urine reaccumulates in the protruded part. A cystocele has not the doughy, inelastic feel of an omental hernia, nor the soft, gaseous feel of an intestinal one, nor does it return with that peculiar gurgling noise which accompanies the ascent of the latter.

The treatment of cystocele, seated in the groin or scrotum, does not differ from that of intestinal hernia. When the tumor is reducible, it should be kept up by means of an appropriate truss; but when the viscus has contracted adhesions, and no longer admits of reposition, the patient must be contented with a suspensory bag. The urine which accumulates in the lower part of the sac must be discharged by raising and compressing the tumor during micturition. If retention should take place, and relief cannot be afforded by the catheter, the part should be punctured. If calculi collect, and become a source of suffering, they may be extracted by incision of the sac.

RETENTION OF URINE.

The symptoms of retention of urine are generally well marked, even at an early stage of the complaint. In this respect, however, there is, as might be supposed, considerable diversity in different cases, depending mainly upon the natural tolerance of the bladder, and the character of the exciting cause of the disease. In paralysis of the muscular fibres of the organ, attended with loss of sensation, the accumulation may make great progress, and yet the individual not be aware of his real condition. A slight discharge of urine, perhaps, occasionally takes place; or if, as often happens, incontinence is soon superadded to the original disorder, the fluid dribbles off incessantly, and thus both patient and physician are lulled into a false security. When, on the contrary, the retention is inflammatory, more or less pain, and frequent inclination to void the urine, with inability to do so, attend the complaint, and at once expose its true nature.

The characteristic *symptoms* are, the existence of a hard, pyriform, circumscribed tumor, corresponding with the middle line, more or less tender on pressure, fluctuating, not affected by change of posture, and gradually increasing in volume; a frequent desire to void the urine, which if passed at all, is discharged in drops, or small jets, never in a full stream, or in any considerable quantity; uneasiness and a sense of weight in the pelvic region, soon followed by pain and spasm; straining, forcing, or tenesmus at every attempt at micturition; at first absence of fever, and then rigors, alternating with flushes of heat, and, in the latter stages of the complaint, excessive restlessness, hot skin, small and frequent pulse, distressing headache, an indescribable sense of oppression, urinous breath and perspiration, typhomania, and a Hippocratic condition of the countenance. In addition to these signs, which none but a most heedless practitioner can mistake, there is also generally, after the first few days, a constant dribbling of urine, and the distended bladder may easily be felt by the finger introduced into the rectum or the vagina.

Death in these cases usually occurs in from three to five days from the commencement of the disease, from uremic poisoning. As the distention progresses, the kidneys are gradually paralyzed so as to be unable to secrete urine, the elements of which are, consequently, retained in the blood, and thus occasion a low, typhoid state of the system, from which few patients ever recover. It has been supposed that, under these circumstances, more or less of the urine in the bladder is absorbed, and carried into the circulation, but this is not at all probable.

In ascites, with which this affection is most liable to be confounded, the abdominal tumor is diffused, not circumscribed, and changes its form and situation with the position of the body; there is little, if any, tenderness on pressure and percussion; the sense of fluctuation is more distinct; the progress of the disease is more tardy; the urine, although more scanty than in health, is voided several times in the twenty-four hours, generally without pain or difficulty; there is commonly anasarca of the lower extremities; the skin is remarkably dry and harsh; and there is usually an absence of febrile disturbance, and always of typhomania and of urinous perspiration. If any doubt exist, the introduction of the catheter will at once dispel it.

A distended bladder has occasionally been mistaken for a supra-pubic abscess. Colot refers to two such cases as having come under his own observation; and

several examples of a similar kind have been reported by more recent writers. On the other hand, a pelvic abscess has sometimes been mistaken for a distended bladder. A very remarkable instance of this description is recorded by Dr. George McClellan, in his work on surgery. The case, that of a man, twenty-three years of age, was under the joint care of Dr. Physick and himself. A large fluctuating tumor existed in the lower part of the hypogastrium, feeling and looking precisely like an overdistended bladder, accompanied by all the symptoms of a painful retention. Only about a tablespoonful of urine, however, followed the introduction of the catheter. The finger, inserted into the bowel, came in contact with what seemed to be an enormous enlargement of the bas-fond of the bladder, and, on making counter-pressure above the pubes, a distinct undulatory movement was detected. The catheter was used again and again with no better result. During the last operation blood appeared in the eyelets of the instrument, and the man felt conscious that something had given way. A trocar was now plunged into the supposed vesical tumor above the pubes, and, to the astonishment of both surgeons, a large quantity of sero-purulent fluid escaped instead of urine. Death occurring within a few hours after the last operation, it was found that the disease was an immense pelvic abscess, caused by the lodgment of a date-stone, swallowed two years previously, in the vermiform process of the colon.

Dr. Smith, of Massachusetts, has reported a curious case, in a man, eighty-two years of age, in which distention of the bladder, simulating retention of urine, was caused by an enormous accumulation of fat around that organ, folding it, as it were, upon itself in such a manner as to form two cavities, the upper and larger one of which contained nearly a pint of fluid. A catheter readily entered the lower pouch during life, but only a little urine, mixed with blood, was obtained.

In advanced pregnancy a distended bladder has sometimes been mistaken for dropsy. Foderé mentions a case in which a trocar was thrust into the child's head across both walls of this viscus, under the supposition that the disease was ascites. In the latter period of gestation, the bladder, in consequence of the resistance offered by the gravid uterus, is spread out, as it were, over the anterior surface of the organ, forming, when distended with urine, a flattened tumor in front and at the sides of the abdomen, which, fluctuating under percussion, might thus lead to a serious error of diagnosis.

The *treatment* of retention of urine is, in the first instance, by the catheter; for the indication is to relieve the distended organ without delay, before the part and system have sustained serious mischief. When there is great accumulation, amounting to several quarts, it will be most safe, as a general rule, not to empty the bladder completely at a single operation, but gradually. The catheter is introduced, and half the fluid is evacuated, to afford the overstretched fibres an opportunity of contracting and regaining their power. Some hours afterwards the instrument is again used, and then the remainder of the urine is withdrawn. When this precaution is neglected, or unavoidable, the abdomen should be supported by a compress and a broad roller. Another important rule is, not to permit the patient, especially if he is old or exhausted, to stand up during the operation, lest, the heart's action failing, he should die from syncope. A large opiate should be given just before or immediately after the operation, if not contra-indicated by cerebral oppression.

An overdistended bladder sometimes bursts from the sheer pressure of its contents, or from the pressure exerted upon it by the diaphragm, as in the violent straining during parturition. A similar effect may be produced by the careless employment of instruments. However induced, the symptoms are always exceedingly distressing and strongly marked. The patient is instantly seized with agonizing pain, and a feeling as if something had suddenly burst, followed by the immediate subsidence of the vesical tumor, and a general enlargement of the abdomen, especially if the previous local distention was unusually great. Sometimes a distinct sense of fluctuation is perceptible. The pulse rapidly sinks, the surface becomes covered with a cold, clammy perspiration, and death commonly ensues within the first thirty-six hours, from the conjoined effects of collapse and peritonitis, the accident being invariably fatal.

Sometimes, again, the distended organ gives way by ulceration, generally through the rectum or perineum, followed by fistulous openings, which it is usually very difficult, if not impossible, to close.

Retention of urine may be produced, 1st, by mechanical obstruction; 2dly, by paralysis; 3dly, by spasm; 4thly, by inflammation; 5thly, by gout and rheumatism; 6thly, by pelvic tumors; and 7thly, by the effects of miasm. Women are liable to a peculiar form of retention of urine, to which the term *hysterical* is usually applied.

1st. The first class of causes may affect either the urethra, the bladder, or the head of the penis.

The *urethra* may be obstructed by an organic stricture, a calculus, a small tumor, clotted blood, plastic matter, or inspissated mucus. A catheter, bougie, or other foreign body may break off in the canal, and thus become an impediment to the egress of the urine.

In organic stricture, the ordinary means are resorted to; if these fail, the only resources are puncture of the bladder and tapping the membranous urethra at the apex of the prostate gland, or behind the seat of the obstruction. In the latter procedure, instead of cutting from without inwards, the artificial outlet for the urine is made with greater safety and precision by a simple puncture in the middle line with a straight or slightly curved bistoury. The patient being in the ordinary lithotomy position, and the tip of the left index-finger being passed into the rectum and brought in contact with the apex of the prostate, the point of the knife is entered at the median raphe, five lines in front of the anus, and thrust upwards and backwards, as if to strike the bulb of the finger, the latter of which guides it into the urethra, the opening in the tube and the soft parts being enlarged during the withdrawal of the instrument. Through the free outlet thus made the urine gushes in a full stream, and continues to dribble for thirty-six or forty-eight hours, when it is passed voluntarily. The retention of a catheter in the wound is entirely unnecessary. This operation, which is as simple as it is effectual, was first practised by Mr. Molins, of London, in 1652, and was soon after repeated by Wiseman. It seems, however, to have been lost sight of until 1815, when Mr. Grainger, of Birmingham, called attention to it, and it has since been successfully performed by Sir Charles Bell, Sir Astley Cooper, Liston, Bransby Cooper, Arnott, Simon, Cock, and other British surgeons, and by Dr. S. W. Gross and Dr. R. J. Levis, of this city.

An impacted calculus may generally be pushed back into the bladder, or extracted with the urethra-forceps. When these means are unsuccessful, it is removed by incision. Pieces of bougie and other foreign bodies are managed on the same principle. Clotted blood, lymph, and inspissated mucus are easily displaced by the catheter, or forced out by the urine. When the sides of the urethra are glued together by adhesive matter, the obstacle can only be overcome by the gentle use of the instrument.

Retention occasioned by congenital occlusion of the urethra is generally easily remedied by the knife and catheter. In retention dependent upon simple narrowing of the canal, steady and judicious dilatation is indicated.

The obstacle may be exterior to the urethra, as an abscess in the perineum, a deep-seated collection of blood, an effusion of lymph, or a malignant tumor. Carcinoma of the penis, contusions of the perineum, and extravasation of urine, the effect of injury or stricture, are frequently followed by the worst forms of retention.

When the obstacle is seated externally, and bulges inwards, so as to occlude the canal, the knife supersedes the catheter. Extravasated blood is treated by sorbents, as acetate of lead, hydrochlorate of ammonia, or spiritous embrocations. In contusions of the perineum, without rupture, the catheter is used; but when the accident is attended by laceration, a large incision is made, to save the tissues from urinary infiltration.

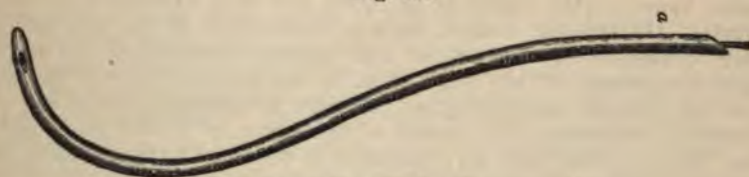
In the second place, the obstruction may be seated in the *bladder*. Of this class of causes, the most frequent are hypertrophy of the prostate gland, coagulated blood, inspissated mucus, lymph, and urinary concretions. The gravid uterus, or any other pelvic tumor, may, by compressing the neck of the bladder or the commencement of the urethra, give rise to a similar effect.

The most common form of obstruction of the bladder, productive of retention of urine, is hypertrophy of the *prostate gland*. The enlargement may involve the entire organ, or it may be limited to one of its lateral lobes, or even to its mammillary process. The obstacle thus occasioned is usually temporary, but it is liable to be reëxcited by the slightest exposure to cold, irregularity of diet, horseback exercise, sexual indulgence, or neglect to empty the bladder.

Great obstacle to micturition, and even complete retention of urine, may be caused by centric enlargement of the prostate, without any material increase of weight or bulk of the lateral lobes. The tendency of such a development is to encroach upon and diminish the caliber of the corresponding portion of the urethra, and, consequently, to interfere more or less with the evacuation of the urine and the passage of instruments.

The treatment is by the catheter; and one of silver is, as a general rule, far preferable to one of gum-elastic. It should be at least twelve inches in length, and its curve should form an arc equal to one-third of the circumference of a circle five inches and a half in diameter, otherwise it may fail to reach the distended reservoir. When the instrument comes in contact with the enlarged gland, the surgeon introduces the left index-finger, well oiled, into the rectum, and, placing it against the beak, he guides it into the bladder, by pushing it gently towards one side, or upwards towards the pubes, at the same time that he urges the handle on with the right hand. In order to empty the bladder entirely, it is necessary, as the point of the catheter cannot reach the cavity behind the gland, to raise the patient's hips, or to turn him on his belly, so as to force the urine out of its hiding place. To obviate this difficulty, Dr. Squire, of Elmira, has devised a vertebrated instrument, the vesical extremity of which is provided with a series of caps, united by a linked wire, an arrangement which not only admits of its adaptation to the changed relations of the prostatic urethra, and, consequently, of its easy introduction, but also of the withdrawal of the residual urine, from its natural tendency to drop into the bas-fond of the organ. In very old men, with inordinate enlargement of the prostate in its longitudinal direction, the silver catheter may be advantageously replaced by a stiff gum-elastic instrument, at least from twelve to fifteen inches in length, one which has been kept on an over-curved stylet, fig. 501, so as to enable the point to pass

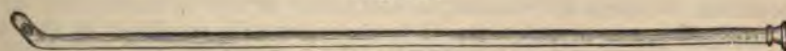
Fig. 501.



Over-curved Gum Catheter.

the more readily over the obstruction. In some cases it is necessary to bend back the shaft of the instrument so that it resembles somewhat an italic S procumbent; while in others the soft, elastic, angular catheter of Mercier, represented in fig. 502,

Fig. 502.



Prostatic Gum-elastic Catheter.

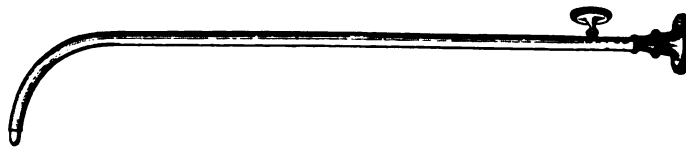
is essential to success, especially if false passages have been made, since, during its introduction, the point is always in contact with the roof of the urethra.

In retention from *abscess* of the prostate, the point of the catheter, as it is urged along, must be kept in close contact with the roof of the urethra, especially as it approaches the arch of the pubes, otherwise it will be liable to become entangled, and thus cause serious suffering, if not great mischief.

Retention of urine from *coagulated blood* in the bladder is a very serious occurrence. When the quantity is very large, relief must be sought by an opening in the perineum, similar to that in lithotomy. Ordinarily, however, evacuation should be attempted with a full-sized silver catheter, with four large eyelets, aided by injections of warm water, and an exhausting syringe. Sometimes the object may be accomplished with a large silver catheter, the orifice of which is completely occluded with an obturator attached to the vesical extremity of a stylet, removed the moment the instrument reaches the bladder. Such an instrument, which I had constructed many years ago, and which I have often used with admirable effect, is represented in fig. 503. The usual hemostatic means are also employed. When

the blood has been recently effused, it is best to wait from six to ten hours, until the fluid has subsided to the bottom of the bladder, when the supernatant urine may generally be withdrawn without difficulty.

Fig. 503.



Blood Catheter.

Retention caused by inspissated *mucus*, plastic matter, worms, or calculous concretions, is, in general, easily relieved by the catheter. When it depends upon the pressure of the gravid uterus, it can only be remedied by rectifying the position of the displaced organ.

Retention of urine is sometimes produced by pressure of the rectum upon the neck of the bladder. Anything having a tendency to cause inordinate distention of the bowel may give rise to such a condition. In 1842, a man died at King's College Hospital, London, after having labored for four days under retention of urine, attended with enormous distention of the bladder. The dissection revealed the presence in the rectum of a pint of gray peas, which had been swallowed nearly a week before, without mastication, and which had experienced no alteration in their transit, except that they had become swollen by the absorption of the moisture of the bowel.

The obstruction may be occasioned by an *imperforate prepuce*. When this is the case, relief is sought by a free incision. In the female, it is sometimes caused by a vascular tumor in the orifice of the tube, and then excision is, of course, the proper remedy. In lying-in women, serious obstruction to the evacuation of the urine is often occasioned by the bruised and swollen condition of the urethra, consequent upon the passage of the child's head or the maladroit use of the forceps.

Retention may depend upon *priapism*, induced by inflammation of the penis, by excessive cerebral irritation, as in lesion of the brain, or by the inordinate use of cantharides. However this may be, recourse is at once had to the catheter, attention being afterwards paid to the removal of the exciting cause.

2d. The bladder may be unable to expel its contents from *paralysis* of its muscular fibres. The most common causes of this condition are apoplexy, injury of the spine, overdistention of the organ, and the effects of fever, contusions, lacerated wounds, and capital operations. The use of anodynes, in large doses, sometimes induces temporary paralysis of the bladder.

In low forms of fever, especially when delirium is present, in compound fractures and dislocations, in lacerated wounds, in contusions of the abdomen, and in strangulated hernia, frequent inquiry should be made into the condition of the bladder, in order to guard against retention, or to relieve it speedily, if it be found to be unavoidable. The liability of this variety of retention to be followed by incontinence cannot be too forcibly or too frequently impressed upon the mind of the reader. It is to this form of the affection that I applied, twenty years ago, in my Treatise on the Urinary Organs, the term *incontinence of retention*, in the hope that, by an antithetical expression, particular attention might be attracted to it. The bladder being distended to its utmost capacity, more or less dribbling is produced, simply by the pressure of the atmosphere, all expulsive power being lost.

Retention from paralysis is relieved by the catheter, and it is better to introduce the instrument frequently than to permit it to remain. When the return of contractility is slow and imperfect, the chief reliance must be upon gentle but steady purgation, the exhibition of strychnia, ergot, cantharides, and tincture of the chloride of iron, the cold showerbath, vesication of the sacrolumbar region, and irritating frictions to the spine. When the loss of power is dependent upon the use of anodynes, cold applications to the head, hypogastrium, perineum, and genitals will usually suffice to afford relief.

Retention from paralysis of the bladder, whether induced by traumatic or internal causes, often ceases very suddenly of its own accord, or under the use of mild

remedies. A mere change of posture sometimes answers the purpose, especially in retention from injury and protracted parturition.

There is a variety of retention of urine which is occasionally met with in *hysterical* females, and which is seemingly dependent upon a deficiency of volition rather than upon paralysis of the muscular fibres of the bladder. The affection is generally temporary, but may last for days or weeks. In a case recently under my care, it had persistently continued for upwards of three years, during the whole of which the urine was drawn off regularly twice every twenty-four hours. Purgatives, asafœtida clysters, and the internal use of antispasmodics and chalybeate tonics, either alone or in union with cantharides, are the remedies mainly to be relied upon. Cold water, poured upon the sacrolumbar region in a continuous stream, from a height of three or four feet, often affords speedy relief. The catheter must, if possible, be avoided. Chloral and bromide of potassium should be freely used. Moral treatment is often the most successful. Too much kindness only tends to prolong the case. In the patient here referred to the threatened application of the actual cautery promptly effected a cure.

It is to this form of retention of urine that the term "stammering of the bladder," first used by Sir James Paget, is more particularly applicable, consisting in a want of harmony between the extrusor and sphincter muscles of the organ, attended with inability to void the urine. In a remarkable case of this kind, in the hands of Professor T. G. Richardson, of New Orleans, in a young girl, eighteen years of age, after the failure of a great variety of means, speedy and permanent relief was afforded by the division of the anterior wall of the urethra from the neck of the bladder to the orifice of the tube. The spasm of the sphincter muscle, which was no doubt the immediate cause of the "stammering" here, was effectually broken up by the operation, the neck of the bladder being thereby placed in a state of repose, and in a condition for its future coöperation with the muscular fibres of the organ.

3d. Retention of urine from *spasm* of the neck of the bladder, or of this organ and of the urethra, is commonly produced by cold, suppression of the cutaneous perspiration, the irritation of ascarides, hemorrhoidal tumors, stone in the bladder, disorder of the digestive apparatus, the use of fermented, vinous, or alcoholic drinks, and the effects of cantharides. The warm bath, hot fomentations, and the inhalation of chloroform, followed by the free use of camphor and morphia, or morphia alone, either by the mouth, the rectum, or the hypodermic syringe, generally afford prompt relief. Cold applications sometimes answer better than warm. A lump of ice introduced into the rectum occasionally acts like a charm, and similar effects often follow the application of this agent to the perineum and supra-pubic region. When the symptoms are urgent, the catheter is used.

In retention, from the absorption of cantharides, known as strangury, the most effectual remedies are anodyne injections, hot fomentations, and the exhibition of liquor potassæ in half drachm doses every hour, along with the liberal use of diluents.

4th. Retention may be produced by *inflammation* of the urethra and the neck of the bladder. The symptoms are a frequent desire to urinate, with an inability to pass more than a few drops of water at a time; a sense of smarting, burning, or scalding in the urethra and the head of the penis; violent straining; a feeling of weight about the anus; and throbbing in the perineum. Occasionally, the urine is mixed with blood and pus.

The treatment is, of course, antiphlogistic. Spasm is allayed by anodyne enemata and the liberal use of diluents. General and local bloodletting may be necessary. The warm bath is highly useful. The bowels are moved by mild laxatives. When the symptoms are urgent, and the means here indicated are ineffectual, the catheter must be introduced. In inflammatory retention, accompanied by spasm of the bladder and urethra, prompt and decided relief is occasionally obtained from the inhalation of chloroform.

5th. The disease is sometimes caused by *gout and rheumatism*, especially in elderly, broken-down individuals long addicted to the pleasures of the table, and to inordinate sexual indulgence. The attack is either coincident with gout and rheumatism in other structures, or it shows itself as a retrocedent affection. In either event, the most suitable remedies are Dover's powder, colchicum and morphia, purgatives, alkalies, and the hot bath.

6th. The retention may depend upon the pressure of a *pelvic abscess*, a solid tumor, or a serous, bloody, or hydatid cyst, developed between the bladder and the rectum. Boyer has recorded an instance in which the obstacle was formed by an exostosis of the pelvic bone; the tumor compressed the neck of the bladder, and prevented the passage of the catheter. Mr. Thomas Bryant, of London, met with a case of retention of urine caused by an immense mass of hydatids which almost completely blocked up the pelvic cavity and pushed the bladder up into the iliac fossa, beyond the reach of an instrument. After three fruitless efforts to perforate the organ with the trocar, an incision was made through the perineum upon the morbid growth, which contained three quarts of hydatids. The man, who was fifty years of age, and who had not voided more than an ounce of urine at any one time for many months, died at the end of the seventh day. The treatment of such obstructions must be regulated by the peculiar nature of the case.

Finally, there is a *periodical* form of the disease which comes on at a particular time, very much like an attack of intermittent fever, and is evidently dependent upon similar causes. It is met with chiefly, if not exclusively, in miasmatic regions. The treatment must, of course, be by quinine, either alone, or in union with arsenic and other antiperiodic remedies.

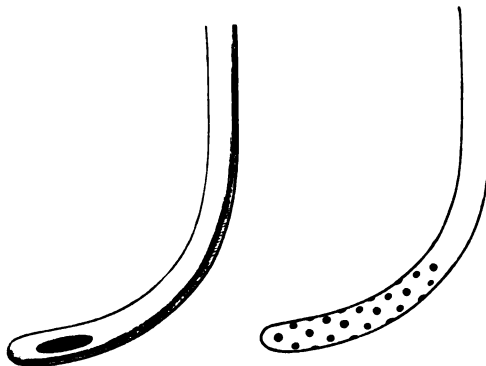
CATHETERISM.

The introduction of the catheter, although apparently very simple, is one of the most delicate operations in surgery. It requires skill of the highest order, as well as the most intimate knowledge of the anatomy of the urinary organs. My conviction is that few men perform it well.

Catheters are cylindrical tubes, of variable composition, size, and shape. The best are made of silver, and are, for an adult, about nine inches and a half long, by two lines and a half in diameter; they are perfectly smooth, light, and bent at the vesical extremity to accommodate them to the natural curve of the fixed portion of the urethra, which, as originally pointed out by Mr. Briggs, of London, corresponds to rather less than one-third of the circumference of a circle three inches and a quarter in diameter. An instrument, widely known as that of Sir Henry Thompson, the axis of the point of which forms a right angle with the axis of the shaft, fashioned to this curve, will be found to be better adapted to the average, well formed, adult urethra, than one which is not constructed on these principles. In children, and adults in whom the general development is below the average, the curve of the urethra is more acute, and hence the curve of the catheter must be increased, or describe an arc of a smaller circle. In corpulent persons, on the other hand, the curve of the urethra being diminished, that of the instrument should form a segment of a larger circle.

Fig. 504.

Fig. 505.



Different forms of Catheters.

This extremity, which is rounded off, but closed at the point, and nearly of the same thickness as the rest of the instrument, has an oval hole on each side, as exhibited, in fig. 504, a quarter of an inch long, and about a line in width, for the entrance of the urine. Instead of this arrangement, this part of the tube is sometimes pierced with numerous little apertures, as in fig. 505, but these are objectionable on account of their liability to become clogged with blood and mucus. For the removal of urine, mixed with these substances, I have had a catheter constructed with eight eyelets. The catheter, represented at page 744, with the opening at the extremity,

and provided with a closely-fitting conical stopper, secured to a stylet, is also well adapted to this object, as the orifice remains closed until the tube is fully in the bladder. The other extremity, usually called the handle of the instrument, is open, and is provided on each side with a small ring, for securing it in its place when it is necessary to retain it in the bladder. The French pocket catheter consists of two

pieces, united by a screw, and is adapted for either sex. The gum-elastic instrument, so much lauded by some practitioners, I seldom employ, except in inordinate enlargement of the prostate gland, as it is extremely liable to bend whenever it meets with the slightest resistance, and is also very easily injured by the urine. It is, however, proper to add that the soft, pliant catheter of the French manufacturers, figs. 506 and 507, especially those with bulbous extremities, pass into the bladder with the greatest ease, and can with safety be intrusted to the patient or to his nurse.

Fig. 506.

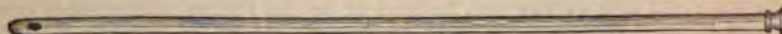
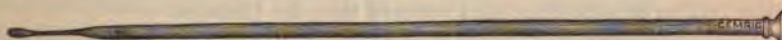


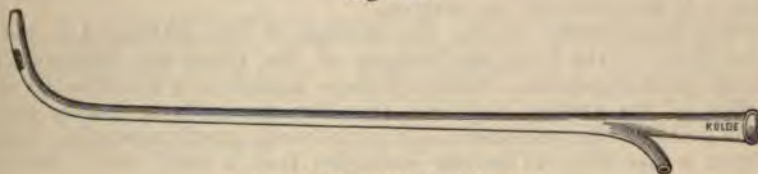
Fig. 507.



French Gum-elastic Catheters.

Indeed, they cannot be too favorably recommended to inexperienced practitioners and bunglers, in whose hands the slightest obstacle to the introduction of metallic instruments is liable to be attended with the formation of false passages. Every surgeon should have an assortment of catheters of different dimensions, that he may be prepared for any emergencies that may arise. For washing out the bladder, for the removal of blood and mucus, or for introducing fluids, a double catheter, fig. 508, is necessary. When the object is to throw up fluids, medicated with acids, as the nitric, hydrochloric or carbolic, a silver instrument is required.

Fig. 508.



Catheter for Washing out the bladder.

When the urethra is entirely sound, a tolerably large catheter, one that will gently distend the parietes of the tube, is selected. An instrument of this size is not so likely to be arrested by the folds and follicles of the mucous membrane, or to impinge against the margins of the opening in the triangular ligament. Previously to inserting it, it should be well warmed and oiled.

The catheter may be introduced while the patient is standing, sitting, or lying; but, whatever posture may be selected, it is important that the thighs should be moderately separated from each other, and flexed upon the pelvis, to relax the abdominal muscles. In the first case, the patient leans with his back against the wall, and inclines his chest slightly forwards, so that he may not change his position during the operation. The surgeon may take his place either at the front or side. If he sit, the breech should project over the chair, and the body be directed backwards. The position of the operator is the same as before. The most convenient posture, however, is the recumbent. The patient lies on his back, near the edge of the bed, the head being supported by a pillow, and the knees, slightly separated from each other, somewhat raised. The surgeon, standing at the left side of the bed, takes the penis in the left hand, and raises it to a right angle with the body to efface the curve which it forms at the pubes. The catheter, held in the right hand, between the thumb and first two fingers, is inserted into the orifice of the urethra, its concavity being directed towards the abdomen with the handle nearly in contact with the middle line. The instrument is now passed on until the beak reaches the sinus of the bulb, which lies upon the anterior surface of the triangular ligament, rather deep in the perineum. To disengage it from the sinus, the handle is changed from the horizontal direction into the vertical, at the same time that the point is slightly retracted. By this manœuvre, the curved portion is brought under the arch of the pubes, and immediately opposite the opening in the triangular ligament. By depressing now the

handle of the instrument so as to bring it into a straight line the point readily glides over the prostatic part of the urethra into the bladder.

In performing this operation not only no force is employed, but the whole proceeding is conducted with the utmost care and gentleness. The catheter, held as lightly as possible, is made to glide along, as it were, by its own weight, assisted by that of the hand. The penis should be drawn slightly forward over the instrument, just sufficiently to render the urethra a little tense. Everything like stretching, pulling, and pushing should be avoided.

In introducing the straight catheter, the patient lies on his back, and the surgeon stands on the right side of the bed, instead of on the left, as in the other case. The penis is held in the left hand, at a right angle with the body, and the instrument is carried down perpendicularly as far as the sinus of the bulb. To free it from this depression, the point is retracted a few lines, and then, while the penis is lowered between the thighs, it is at once sent onward into the bladder.

When, from any cause, the bladder is permanently disabled from expelling its contents, the patient should be taught to introduce the catheter himself, as this will save the surgeon an immense amount of labor and inconvenience. A few lessons generally suffice to impart the requisite information, and it is surprising how well the operation is often executed. The frequency with which the operation is repeated must, of course, vary with the nature of the case, from three to six times in the twenty-four hours. Although I have known men to draw off their urine a dozen times a day for years with perfect impunity, yet it may be laid down, as a rule, that, in most cases, when the instrument is obliged to be used for any considerable period, it will gradually set up a slow form of inflammation in the prostate gland and mucous membrane of the bladder, under the effect of which, if proper care be not taken, the patient will ultimately succumb. The frequent use, indeed, of any instrument in the urethra and bladder is a great evil, and should, therefore, be scrupulously avoided whenever it is in the power of the surgeon.

The natural impediments to the introduction of the catheter are, the *lacuna magna*, the sinus of the bulb, the margins of the triangular ligament, and the orifices of the prostatic ducts. Nearly all these impediments are situated along the under surface of the urethra, and may, therefore, generally be readily avoided by pressing the point of the instrument, as it glides along, gently upwards. A tolerably large catheter is less likely to become entangled than a small one. The difficulty occasioned by hypertrophy of the prostate gland is usually easily surmounted by the insertion of the finger in the rectum. When the retention depends upon displacement of the posterior part of the urethra, or of the neck of the bladder in consequence of centric hypertrophy of the prostate gland, a gravid or dislocated uterus, or the existence of a pelvic tumor, much ingenuity will frequently be required to accomplish the object.

Various contrivances are used for retaining the catheter in the bladder. The one which I usually prefer is the double T bandage, the thigh-pieces of which are fastened in front and behind in such a manner as not to interfere with the anus and the scrotum. The instrument, having been introduced, is secured by two strips of linen, tape, or oiled silk, by tying the middle of each to the ring of the catheter, and the ends to the vertical bands. Another very good plan is to surround the penis with an ivory, elastic, or linen yoke, secured to the pubes by means of four pieces of tape, carried around the thighs and pelvis. The catheter is fastened to the ring or yoke in the usual way. In the annexed drawing, fig. 509, the instrument is secured to a piece of linen passed around the penis, just behind its head. The contrivance, however, is objectionable, on account of its liability to injure the penis, in case of erection, and to slip when the organ is flaccid.



Mode of Securing the Catheter in the Bladder.

To prevent undue pressure upon the mucous membrane of the bladder, the catheter, if intended to be retained, should be at least two inches shorter than one used for merely drawing off the urine. What is called a Syme's catheter is by far the most suitable and convenient instrument for permanent retention.

The winged or self-retaining gum-elastic catheter of Mr. Holt can never come into general use, on account of the irritation which it is liable to set up.

The introduction of the catheter is sometimes followed by unpleasant effects, as partial syncope, more or less violent shock, epileptiform convulsions, and even death. These occurrences are most common in persons of a nervous, irritable temperament, and cannot always be prevented, however carefully and gently the operation may be performed. The best way to avoid them is to insert the instrument, properly oiled and warmed, in the recumbent posture. The effects generally pass off speedily of their own accord. The most suitable remedies, in the event of their being troublesome, are the administration of hot brandy toddy, the inhalation of chloroform, and the hypodermic injection of morphia.

It is much easier to rupture the bladder with a catheter or sound than is generally supposed. A number of cases have been recorded where, from this cause, death was produced. Velpeau states that a surgeon in one of the Parisian hospitals introduced a catheter into a man's bladder, but, finding no urine, he thrust the instrument up with great force, and drew off a large quantity of serous fluid, which, as the dissection showed, had accumulated in the peritoneal cavity, the case having been one of ascites.

PUNCTURE OF THE BLADDER.

When the catheter, bougie, and other means have failed to procure relief, the only thing that remains to be done is to puncture the bladder. Fortunately, this operation is seldom necessary. It is only in cases of excessive enlargement of the prostate gland, attended with great tenderness and swelling of the surrounding parts, in laceration of the urethra, infiltration of urine into the scrotum, and in deep-seated, impassable stricture, that the operation should ever be seriously thought of. I have myself been obliged to perform it only twice, and then in cases not my own.

There are three routes by which the organ may be approached when paracentesis becomes necessary, the rectum, hypogastrium, and pubic symphysis. Of these, the first is the one usually preferred, on account of the facility of performing the operation, and its supposed freedom from the danger of urinary infiltration. It is, of course, contra-indicated when there is great enlargement of the prostate gland, or serious disease of the anus, rectum, or bas-fond of the bladder. The operation is occasionally followed by peritonitis; and cases have been reported in which it gave rise to emphysema, extending to the upper parts of the body.

Fig. 510.



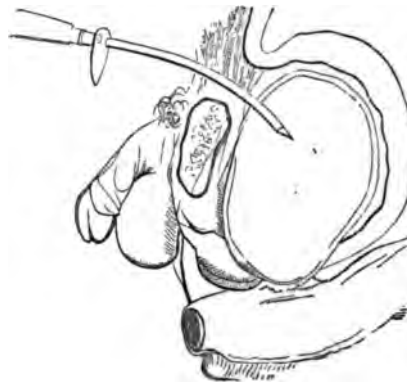
Rectal Puncture of the Bladder.

a. The *rectal puncture* is executed with a curved trocar, about four inches in length, and provided with a suitable canula. The patient's breech is brought over the edge of the bed, and his legs are supported by two assistants, as in the operation for stone. The surgeon, oiling the index and middle fingers of the left hand, introduces them into the bowel, in contact with its anterior wall; he then takes the instrument in the right hand, and retracting the point of the trocar within its sheath, places it in the groove formed by the junction of the two fingers. When the instrument has passed the posterior margin of the prostate gland, the handle is depressed, and the point urged on through the superimposed structures into the interior of the bladder, as shown in fig. 510. The want of resistance, and a slight escape of urine, will indicate that the instrument has reached its destination. By a sort

of double movement, the trocar is now withdrawn, and the on into the distended viscus. The urine being evacuated, once removed, or, if there is any serious obstacle along the retained until this is surmounted.

b. The *supra-pubic puncture* is objectionable, because of escape of urine into the peritoneal cavity and the surround

Fig. 511.



Supra-pubic Puncture of the Bladder.

In executing it, the back, the skin is divided in the middle line, from an half in length, according to the parts, first through the cellular tissue which organ. Through this pierced at its lowest point being inclined obliquely backwards in the direction of the sacrum. Then the trocar is withdrawn, and the catheter is passed into the bladder, retained by an appli

the obstruction necessitating the operation has been removed. The patient, in the mean time, lies on his side, to promote the escape of the urine.

c. The *inter-pubic puncture* of the bladder was first proposed by Jersey, in 1825; and, although it has been performed successfully, among others, by Dr. Leasure, of Allegheny City, it warrants to express any opinion respecting its relative and absolute merits. The instrument, a hydrocele trocar of medium size, is introduced into the centre of the pubic symphysis, somewhat obliquely downwards towards the sacrum, and, consequently, only a short distance. A piece of flexible catheter is introduced through the canula, in the same manner. The operation has the advantage of facility of evacuation from infiltration.

INCONTINENCE OF URINE.

Incontinence of urine, the reverse of retention, with which it may occur at any period of life, and may be partial or complete. It may be excited by a great variety of circumstances, of which, however, are referable to external injury, or to paralysis, or morbid sensibility of the bladder, or of this organ. Water may pass off as fast as it is secreted, or it may be retained either dribble away or be discharged in a full stream.

a. The best example of incontinence from *external injury* is a kick, blow, or fall, upon the perineum is occasionally followed by incontinence from this cause often disappears spontaneously, but it is occasionally incurable. The treatment must be conducted on general principles.

b. Incontinence from *inflammation* may depend upon various causes. The escape is usually partial, and is almost constantly associated with spasm. The treatment consists in removing the exciting cause, the lancet, the hip-bath, antispasmodics, and anodyne injections afford instant relief.

c. The disease is occasionally induced by *gout* or *rheumatism*, usually coming on as a secondary affection, being translated from the bladder, the mucous and muscular tunics of which are highly sensitive, with a constant inclination to micturition. The bladder is surcharged with lithates, and there is always marked disorder of the system. Relief is afforded by thorough purgation, a careful reg

the exhibition of colchicum and morphia, Dover's powder, and the alkalies. If the patient is very plethoric, blood may be taken from the arm; if anemic, recourse must be had to tonics and stimulants.

d. *Paralysis of the bladder*, or of this viscus and of the urethra, however induced, is a frequent cause of incontinence. It is particularly liable to supervene upon injury of the brain and spinal cord. It also occasionally follows parturition. Owing to the fact that the sphincter muscle generally retains some contractile power, more or less of the urine accumulates in the bladder, while the rest gradually passes off, leading thus to a belief that the case is one purely of incontinence, when, in reality, it is one both of incontinence and retention.

The remedies, in the treatment of this affection, must be addressed chiefly to the invigoration of the nervous system. For this purpose, after having cleared out the bowels and corrected the secretions, the patient is put on the use of strychnia and ergot, either alone or combined with some mild tonic, as extract of cinchona and sulphate of iron. Cantharides may also be advantageously given, especially if carried to the extent of slight strangury. The diet should be light, but nutritious. The cold shower-bath, followed by dry frictions, is often highly beneficial. Counter-irritation by blisters is maintained in the sacrolumbar region. Occasionally prompt relief is afforded by injecting the bladder daily with a few ounces of cold water.

e. Incontinence may arise from *morbid sensibility* of the neck of the bladder, or of the entire organ, excited by the acid character of the urine, or by sympathy with the kidney, rectum, anus, vagina, or uterus. Masturbation and inordinate sexual indulgence may be followed by a similar result. In most of these instances, the disorder is incomplete. Maniacs are very liable to attacks of incontinence, apparently due to excessive morbid sensibility of the bladder, probably the result of self-pollution.

To this variety of the affection obviously belongs that form of the disease known as *puerile incontinence*. Although it is most frequent in young, delicate boys, before the age of ten, it is by no means uncommon in girls. It often begins very early in life in both sexes, and occasionally continues long after the age of puberty, greatly to the annoyance, both physical and mental, of the poor sufferer. The discharge, which may take place several times during the night, is most common towards morning, and is sometimes effected under the influence of the will or of a dream, but, in general, it is strictly involuntary. When it becomes habitual, as it usually does, it may last for years. In most cases, however, it gradually disappears on the approach of adolescence. It is promoted by the use of fluids, by exposure to cold, and by sleeping on the back, a posture favorable to the accumulation of urine in the morbidly sensitive portion of the bladder.

In boys one of the most common exciting causes of this affection is masturbation, which, in confirmed cases, frequently keeps up the incontinence until a late period of life. In young children it is often produced by ill health, arising from improper feeding and want of good air and exercise, followed by disorder of the digestive organs; by malarious diseases; by worms in the alimentary canal; by the inordinate use of saccharine drinks; and by the irritating properties or the excessive quantity of the urine.

In the treatment of this form of incontinence, particular inquiry should be made into the nature of the exciting cause, the removal of which is of paramount importance. In that variety of the affection which is met with in boys and girls, the cure may be greatly expedited by proper attention to the diet, which should always be bland and unirritating. Late suppers are avoided, and the patient must abstain entirely from drink for several hours before going to bed. During the night, he should be compelled to rise two or three times to empty his bladder, and this practice should be persisted in for weeks and even months, until the disagreeable habit is thoroughly broken up. During all this time, as well as, indeed, for a long period afterwards, the child should lie upon his side, to prevent the urine from coming in contact with and irritating the neck of the bladder. The internal remedies from which I have derived most benefit are strychnia and cantharides, given three times a day, in the proportion of the thirtieth of a grain of the former to about the twentieth of a grain of the latter, according to the age of the subject. A minute portion of morphia forms a valuable addition; and, in atonic cases, I often combine with these articles some preparation of iron, especially the tincture of the chloride. When strychnia disagrees, or fails to answer the purpose, extract of *nux vomica*

may be used as a substitute. In either event, it is important to watch the effects of the remedy. I have great confidence in the use of cantharides in this affection, having known it to afford relief when everything else proved unavailing. I prefer the powder to the tincture, and occasionally continue the exhibition until slight strangury is induced. Benzoic acid has also been highly recommended, but the trials I have made of it have disappointed my expectations. When the morbid sensibility of the bladder is connected with inflammation, balsam of copaiba, in doses of five to fifteen drops every eight hours, is sometimes beneficial. In this variety of the affection a full anodyne at night, especially in the form of Dover's powder, often exerts a happy effect in controlling the discharge.

Many practitioners have great confidence in the efficacy of belladonna in nocturnal incontinence of urine, some regarding it almost as a specific. That the remedy is a valuable one, is certain, but the results of my experience are altogether opposed to such a sweeping conclusion. It should be administered in small doses, as five to eight drops of the tincture, three times in the twenty-four hours, with an occasional intermission for a few days, especially if it causes confusion of sight or redness of the skin. A steady perseverance in the medicine, for several months, is generally necessary to insure a cure. I have, however, met with several obstinate cases of nocturnal incontinence in boys in which a permanent cure was effected by the subcutaneous injection daily of ten drops of the tincture of belladonna.

Great benefit often occurs, especially in nervous persons, from the use of the bromides in the treatment of this affection. They should be administered in full and sustained doses, either alone, or in union with chloral, morphia, and other articles. Chloral alone sometimes speedily arrests the complaint when every thing else fails.

The cold shower-bath should be used twice a day, or cold water poured from a considerable height upon the lower portion of the spine, and blisters applied to the sacrolumbar region, the perineum and thighs. In obstinate cases, the neck of the bladder is cauterized, as in spermatorrhœa, only much more mildly. In the female the application is made to the orifice of the urethra, and a similar expedient sometimes answers a good purpose in boys, the urine, as it comes in contact with the tender surface, waking them up, so as to induce them to rise and empty the bladder.

The application of pressure to the urethra, gentle but steady, and gradually increased, has sometimes been found beneficial in removing the complaint; and Dr. Corrigan, of Dublin, warmly recommends closing the preputial orifice with collodion, which is easily removed with the finger nail on the following morning, or whenever the child desires to pass water.

In nocturnal incontinence, one of the chief duties of the practitioner is to secure the coöperation of the patient. The child must be reasoned with, and even threatened with chastisement; of course, he is not beaten, nor does any sensible man, at the present day, ever think of tying up the penis.

Some interesting facts in relation to nocturnal incontinence of urine, as it occurred, in 1857, in the Philadelphia House of Refuge, have been published by Dr. Addinell Hewson. Of 292 boys, not less than 78 were simultaneously affected with the disease. Of the 78, however, only 63, inclusive of 34 negroes, were under constant surveillance. The ages ranged from seven to eighteen years, the average being thirteen. Many of the boys bore the marks of ill health, especially of disorder of the digestive organs: 24 suffered from ascarides; some had herpes; 20 labored under constipation; and nearly all were suspected of masturbation, eighteen acknowledging their guilt. The prepuce was discolored and elongated, either from frequent scratching or pulling, in not less than 46 cases. A considerable number wet themselves both day and night. The urine deposited uric acid in nearly one-half of the cases. The use of stimulating food, and sudden atmospheric changes, always produced a marked increase of the disorder. The remedies which proved most efficacious were the juice of belladonna, prepared according to Bentley's process, magnesia, the cold douche, and a reduced supper of bread, without any drink. Those who had worms were treated with turpentine and bicarbonate of soda. Each boy was compelled to get up and micturate an hour after retiring at night. Under this treatment, especially the influence of a restricted diet, enjoined as a punishment, the endemic rapidly disappeared.

Finally, when the incontinence is irremediable, a urinal should be worn, to prevent the fluid from soiling the clothes. The best contrivance for this purpose is a gum-elastic bag, shaped somewhat like a Florence flask, capable of holding about twelve

ounces, and furnished at its inferior extremity with a screw, for the purpose of evacuating the urine after it has accumulated to some extent in the artificial reservoir. The interior should be frequently washed for the sake of cleanliness, and every patient should be provided with an extra vessel, so that he may not suffer any inconvenience in case of accident. A urinal now much used is a gum-elastic bag attached to the inside of the leg, and connected by a tube with the penis. It is much more convenient than the old contrivance.

MORBID CONDITIONS OF THE URINE.

The urine, both in disease and injury, often deviates in a remarkable degree from the normal standard. The most important alterations to which it is liable are referable, first, to its color, odor, and consistence; secondly, to its quantity and specific gravity; thirdly, to an increase of its more important normal constituents; and, fourthly, to its admixture with various extraneous substances, as blood, fibrin, albumen, pus, and spermatic fluid.

1. Naturally the urine is of a light amber *color*, or of the color of pale sherry, especially if water has been largely used. The fluid that is voided in the morning is generally a few shades darker, and during the progress of fevers and acute affections it not unfrequently assumes a deep hue, so as fully to justify the word high-colored, then so commonly applied to it. In certain affections of the bladder and kidneys, particularly in chronic cystitis, it is sometimes remarkably dark, either at the moment it is passed, or after it has stood awhile. A whitish, milky, or lactescent appearance of the urine is usually indicative of imperfect assimilation. Bile renders the fluid yellowish; blood, smoky or reddish; melanic acid, blackish. A bluish urine is sometimes observed, owing to the presence of uroxyanthin. Various articles of diet and of medicine impart their specific hue to the renal secretion.

In inflammatory affections, as the different forms of fever, gout, rheumatism, pneumonia, pleurisy, erysipelas, wounds, and hectic irritation, the urine is always abnormally red, or even pink, from the presence of purpurine. In nervous diseases, as hysteria, epilepsy, and hypochondriasis, it is remarkably clear, if not actually limpid. In diabetes, in which the fluid is often thrown off in vast quantities, the color is very pale. Urine depositing cystine generally exhibits a peculiar yellowish tint, similar to that of honey.

The *odor* of this fluid is naturally a little aromatic, not unlike that of healthy perspiration, without acidity or alkalinity. In certain diseases, it becomes remarkably fetid, occasionally even before it is voided, and always after it has stood for some time in the receiver. Asparagus, garlic, cubebs, turpentine, valerian, gin, and other articles invariably impart their peculiar odor to it. In diabetes it has a whey-like smell, while in the cystine diathesis it resembles the odor of the sweet briar. In injuries of the spine, and in diseases of the bladder, dependent upon calculus, stricture of the urethra, or enlargement of the prostate gland, it generally exhales a most offensive, ammoniacal odor. Sometimes the smell strongly resembles that of putrid cabbage, owing, probably, to the disengagement of sulphuretted hydrogen.

The *consistence* of urine is subject to much diversity, and often affords important diagnostic information. An aqueous state of the fluid is generally denotive of nervous disease; it is commonly associated with lightness of color, and low specific gravity. In inflammatory affections, whether idiopathic or traumatic, the urine is usually very thick, owing to the presence of an abnormal quantity of mucus, lithic acid, and other extraneous matter. In disease of the urinary apparatus, especially chronic cystitis, inordinate consistence is generally combined with remarkable viscosity.

2. The *quantity* of urine excreted by a healthy adult, in the twenty-four hours, is from 35 to 40 ounces, from which it may range from 20 ounces, as the minimum, to 55 ounces, as the maximum. In diabetes it often amounts to several gallons during this period for days together; it is also frequently very abundant in nervous diseases, particularly in hysteria. In inflammatory affections, on the other hand, the quantity is always greatly diminished, especially during the early stages of the attack. In dropsy, there is generally a remarkable deficiency of urine, the quantity being often less than one-sixth the normal standard.

The *density* of the urine is liable to be influenced by various circumstances. On an average, it is about 1022.5 in the healthy state. It is increased by copious per-

spiration, active exercise, heat, dry food, and all articles containing much azote; diminished by the liberal use of water, the lighter wines, malt liquors, vegetable food, cold, and sedentary habits. In disease, it varies from 1001, as the minimum, to 1055, as the maximum.

3. An increase or diminution of the normal constituents of this fluid is of frequent occurrence, and, therefore, capable of affording valuable diagnostic information.

The *water* of the urine, as it naturally exists in greater abundance than any other ingredient, amounting generally to about 933 parts in the 1000, is subject to remarkable changes. In nervous affections, especially in such as partake of a hysterical character, the fluid is always very copious, as well as very thin and limpid. In diabetes insipidus, it is highly aqueous, and is excreted in enormous quantities; it is destitute of urea, and deposits, on evaporation, a yellow-brownish syrup, devoid of crystals, and possessed of a very feeble reaction. In general, comparatively little water exists in the urine in inflammatory affections.

The amount of *urea* voided in the twenty-four hours varies with the nature of our food, drink, exercise, and health, its excretion, according to Roberts, being at the rate of $3\frac{1}{2}$ grains per pound weight of the body. A purely animal diet affords, according to Lehmann, 821 grains, a mixed 501, a vegetable 347, and a non-nitrogenous 237. Urea is furnished very sparingly in acute and active diseases of the kidney, while its elimination is diminished in chronic diseases. In all other acute febrile and inflammatory affections the quantity is increased. Sometimes the kidneys refuse to secrete it, and then, as it is retained in the blood, it acts as a poison, causing headache, nausea, depression, and convulsions; in fact, all the phenomena of uremic disturbance, speedily followed by death.

The *acid* of the urine is most abundant for some time after the completion of digestion; during the continuance of this process, the quantity is very slight, or the fluid may even exhibit a neutral or alkaline reaction, especially if the meal has been a vegetable one. As a general rule, it may be stated to be in an inverse ratio to the amount of gastric juice. Errors of diet, and whatever has a tendency to impair the powers of the stomach or to dry up the cutaneous perspiration, increase the acid of the urine. Hence, it is generally present in undue quantity in dyspepsia, gout, rheumatism, and in intermittent, traumatic, and other fevers. It is also very much augmented by the internal use of various kinds of acids, as sulphuric, nitric, phosphoric, and tartaric.

An *alkaline* condition of the urine is met with in various states of the system. It is generally present, in a very high degree, in disease of the urinary apparatus, dependent upon injury of the spinal cord, or mechanical obstruction of the urethra, leading to hypertrophy and chronic inflammation of the bladder. The pus or gelatinous mucus which is formed in such cases by the affected mucous membrane acts as a kind of ferment, causing decomposition of the animal matter, and thus completely depriving the urine of its acid. A purely vegetable diet soon renders the urine alkaline; and a similar effect is occasioned by the exhibition of the salts of soda and potassa. An alkaline condition of this fluid, then, is not necessarily inconsistent with health; it is only, or chiefly, when it is associated with the presence of carbonate of ammonia or the phosphates that it should be regarded as pathological.

The *mucus* naturally existing in this fluid is greatly augmented in certain diseases. In cystorrhœa, for instance, it is so abundant as to impart to this affection its characteristic feature. When this substance is thrown off in inordinate quantity, it is generally very thick and ropy, and so tenacious as to adhere more or less firmly to the bottom of the receiver. The urine with which it is associated is usually alkaline, and remarkably prone to decomposition, even in the bladder. When the disease upon which it depends is at all severe, or of long standing, it is nearly always intermixed with pus and fibrin, lymph corpuscles, epithelium, and phosphatic matter.

During health, the lining membrane of the genito-urinary organs is constantly engaged in throwing off *epithelium*, the quantity of which is always materially increased when there is serious disease of these structures. The cells, fig. 512, from Roberts, are of variable size, and of an oval, cylindrical, caudate, or irregularly angular and flattened shape, with a well-marked central nucleus; sometimes they are broken up, and disposed in patches or lamellated plates. They frequently occur in combination with oxalate of lime, and in certain affections, especially organic disease of the kidneys, they contain oil globules.

4. Various substances find their way into the urine, either through accident, injury,

or disease. Of these, the most important, practically considered, are blood, fibrin, albumen, pus, and spermatic fluid.

Fig. 512.



Epithelium from the Bladder, Ureter, and Pelvis of the Kidney.

Fig. 513.



Blood Corpuscles.

The presence of *blood* in this fluid may be due to various causes, as injury and ulceration of the genito-urinary apparatus, a renal or vesical calculus, or the existence of an encephaloid, papillary, or erectile tumor. It may generally be readily detected, especially if recently effused, by the reddish color which it imparts to the urine, by its tendency to subside to the bottom of the receiver, and by its alkaline properties. The most infallible plan, however, is to place a little of the suspected fluid under the microscope, which, if it contain blood, will at once detect the peculiar corpuscles of that substance, as displayed in the annexed sketch, fig. 513, representing these bodies unchanged, and either single or aggregated, or shrivelled and crenated, as seen to the right of the figure, when the urine has stood for some time.

Fibrin, plasma, or lymph, is nearly always present in the urine in serious disease of the kidney and bladder. It frequently occurs in distinct flakes, fragments, or little masses, of a whitish or drab-colored appearance, and, under the microscope, always exhibits the peculiar features of that deposit. In renal affections, fibrinous casts are often found in the urine, generally in association with pus corpuscles, blood disks, oil globules, and epithelial cells.

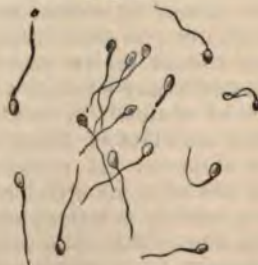
Albumen exists in the urine in many affections, both of the kidneys and of other organs. It is often present in traumatic and idiopathic fevers, pneumonia, dropsy, phthisis, and even in prurigo. It is generally very abundant in Bright's disease, of which it forms a characteristic feature. The urine with which it is associated is of low specific gravity, from deficiency of urea and salts, of a pale, opaline color, and readily coagulable by heat and nitric acid.

Fig. 514.



Pus Corpuscles.

Fig. 515.



Spermatozoa.

Pus is a very common ingredient of urine, and is generally denotive of serious disease of the genito-urinary apparatus. Its presence, however, may be purely acci-

dental. The urine with which it is combined always contains albumen and mucus, is more or less turbid in its appearance, readily putrefies, and generally affords an alkaline reaction. After the fluid has stood for a while, the pus collects at the bottom of the receiver, as a yellowish, homogeneous stratum, of variable thickness. Under the microscope, it exhibits the characteristic globules, delineated in fig. 514.

Seminal fluid is, perhaps, more frequently present in the urine than is commonly supposed. More or less usually exists in all confirmed cases of masturbation and venereal excesses. The microscopical appearances are well shown in the accompanying sketch, fig. 515, representing spermatozoa. These bodies are not unfrequently found in the urine in health; and they may generally be easily detected in this fluid, if it be examined soon after it has been voided, with a power of four to five hundred diameters. Care should be taken not to mistake for zoosperms fragments of cotton, linen, and other vegetable substances, as they sometimes assume forms very closely resembling them.

Besides these ingredients, numerous others are often found in the urine, as urea, urates, uric acid, bile, sugar, oil, cystic and xanthic oxides, oxalate and carbonate of lime, and the triple phosphates. A few cases have been met with in which this fluid contained hairs, short, destitute of bulbs, commonly of a light color, and combined with an excessive secretion of white, chalky matter. Their source has not been determined. The probability is that they are sometimes derived from the ovary.

The examination of the urine with a view to the detection of its more important morbid changes demands skill and patience. The apparatus required for the purpose consists of a microscope, a urinometer, several test tubes, and a spirit lamp, with a few chemical reagents. Simple inspection with the unassisted eye is seldom satisfactory.

The urine usually selected for investigation is that passed in the morning. Of this form four to six ounces should be put into a conical glass, in which it should remain undisturbed for at least two hours, in order to afford an opportunity for the separation of its constituents. A note is now made of its color, odor, and reaction, the appearance of the floating matter, and the nature of the deposit. If it be acid, it will turn blue litmus paper red, and red litmus paper blue if alkaline. A reddish brick-colored sediment indicates an excess of acid. If the alkali is fixed, the blue tint will be permanent; but if it is occasioned by the presence of ammonia, the test paper will resume its original hue on the application of gentle heat. Mucus, pus, and blood, especially if present in large quantity, may generally be readily detected with the naked eye; but the most satisfactory result is always furnished by the microscope, a drop of the deposit being placed upon a glass under the field of the instrument. The characteristic properties of these substances have already been pointed out. The epithelium found in the urine generally proceeds from the kidney and the bladder: in the former case the cells are small and more or less spherical, in the latter flat and scaly. Any doubt that may arise as to the source of the blood, may generally be satisfactorily solved by the presence or absence of renal casts.

Among the most reliable tests for albumen are heat and nitric acid, the former coagulating it, the latter throwing down a flocculent, white precipitate. Deception, however, may arise: thus, if phosphates exist in the fluid, heat may cause a cloudy deposit resembling albumen, although this may readily be dissipated by the addition of a little nitric acid, if the turbidity is owing to the earthy salts, whereas it will be permanent if caused by animal matter. Again, albumen may be present, but, the urine being alkaline, no coagulation may occur. When this is the case, the normal acid reaction should be restored by the addition of acetic acid before it is boiled. Finally, nitric acid may produce a precipitate when there is no albumen, but simply an admixture of urates. The addition of heat promptly clears the urine.

The carbolic acid test of Méhu, recently introduced, is a very delicate one for the detection of albumen. It consists of one part each, by weight, of crystallized carbolic acid and of commercial acetic acid, dissolved in two parts of alcohol, 90 p. c. If 10 c. c. of this solution, which retains its properties without change for an indefinite time, be added to a mixture of two ounces of urine and 2 c. c. of commercial nitric acid, the albumen will be precipitated in the form of white flakes. If the albumen exist in large quantity, or if this substance is surcharged with salts, the addition of nitric acid will not be necessary.

Urea may be detected by adding to urine, in a watch-glass, an equal bulk of colorless nitric acid. If it exist in excess, irregular hexagonal crystals of nitrate

, of a pearly lustre, and easily recognizable with the microscope, will speedily disappear, if the quantity be very small, they will not appear for some time.

The presence of *bile* is ascertained by mixing a drop of nitric acid with a small quantity of urine on a white plate, and observing the play of color that takes place, more or less rapidly from green to violet, blue and red.

Bile acids are easily recognized by dissolving a drop of syrup in a drachm of water in a porcelain capsule, and then slowly adding two-thirds of its bulk of sulphuric acid. On the application of gentle heat, a cherry red color is produced, which soon passes into a deep purple.

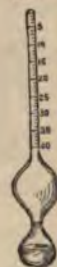
For the detection of *sugar*, the most simple test is Böttger's. It consists in mixing urine with one-half its bulk of the officinal solution of potassa, a small quantity of subnitrate of bismuth having previously been added to the mixture. The presence of saccharine matter is announced by the precipitation of a dark gray powder, due to the conversion of the suboxide into metallic bismuth. The high specific gravity which accompanies this formation is remarkably clear, aqueous, of high specific gravity, the average being 1044, and of a peculiar whey-like odor. It seldom contains any sediments.

Gum matter exhibits, under the microscope, transparent, characteristic oil globules. Its presence may also be detected by ether, by adding an equal quantity to the urine, and then gently evaporating the mixture. The residue will be greasy, immiscible with water, and pervaded by oiliness. The urine, when much of this substance is present, is of a turbid, milky aspect.

The *specific gravity* of this fluid may readily be determined with a urinometer, sketched in fig. 516, floated in a tall, narrow cylindrical vessel containing about six ounces of urine. The number on the graduated stem, on the level of the fluid, will, if added to 1000, give the specific gravity. A specific gravity bottle will afford a more accurate result. It should be capable of holding 1000 grains of distilled water at a temperature of 60° of Fahrenheit. The urinometer, being counterpoised, is filled with urine, the weight of which will represent its specific gravity.

For a more full and detailed account of the morbid conditions of urine, and the various methods of detecting them, than is consistent with the limits of this work, I must refer to the admirable monographs of Frick, Bird, Beale, and others.

Fig. 516.



Urinometer.

URINARY DEPOSITS.

Only deposits in perfectly healthy urine are a slight amount of mucus and cellular debris, which gradually subside in the form of a delicate cloud as the fluid is allowed to stand. In various abnormal conditions of this excretion, either from excess of constituents, from a hyperacid condition, or, again, from an alkaline state, owing to the fixed or volatile alkalies, other precipitates occur. The most common are, first, uric acid, either pure or combined with some bases; secondly, uric acid, as the phosphate of lime, the phosphate of magnesia, or what is called the triple phosphate, consisting of a combination of phosphoric acid with lime and ammonia; thirdly, oxalic acid, in combination with lime; and, fourthly, uric acid and xanthine. The latter two substances, however, are very uncommon.

Uric acid, fig. 517, appears as a deposit in crystals, under varied forms, of which the rhombic prism and its modifications are the most common. The urates themselves are amorphous sediments, of which there are two, the yellow and the red. The color, in the former, is probably owing to hematine; in the latter, to a dark pigment, termed purpurine.

Uric acid and the urates are distinguished from all other deposits by their solubility in nitric acid, on the addition of a drop of the concentrated fluid to a small quantity of the secretion. The first perceptible effect is an effervescence, followed by solution; and, on drying the mass carefully over a spirit lamp, a beautiful crimson tint is produced, termed alloxanthin. The color is converted into a deep purple much heightened by subjecting the residue to the fumes of ammonia due to the formation of murexide or purpurate of ammonia. The two deposits are also distinguished from each other on the application of heat.

The *crystallized sediments*, red sand, or gravel, consist of lithic acid, nearly in a pure state. They appear in the form of minute particles, resembling very much in shape, size and color, the particles of Cayenne pepper, and are always indicative of hyperacidity of the urine. Heat does not dissolve them, as it does lithate of ammonia. Under the microscope, they are found to consist of exceedingly delicate crystals, most of which have the appearance of rhombic prisms, which may, therefore, be presumed to be their normal form. The most perfect specimens are generally contained in the deposits of yellow sand in the urine of young infants. The crystals are sometimes nearly square; or they are very thin, and longer than broad, so as to represent square tables; or, finally, they are so thin as to appear merely like pale, lozenge-shaped lamellæ. Occasionally they lie across each other, and are firmly coherent, forming glomeruli or aigrettes.

The *lateritious sediment*, as it is termed, is colored by the pigment of the urine, and is composed of urate of soda, in union with a small proportion of urate of ammonia and lime.

Fig. 517.



Uric Acid.

Fig. 518.



Amorphous Urates.

The urates, Fig. 518, appear as a colored, amorphous deposit, and are redissolved on heating the urine, which is not the case with uric acid. An excess of the yellow deposit may generally be regarded as denotive of disturbance of the digestive functions, or disorder of the cutaneous transpiration. The urine depositing this substance is of a pale amber tint, more or less acid, and clear when voided. Its quantity is commonly confined within the natural limits, its specific gravity ranging from 1015 to 1025.

The red deposits are always present in those states of the system which are attended with imperfect assimilation, or a want of proper aeration of the blood. The pink sediment, described by Prout, is merely a variety of this; it is exceedingly rare, and is generally expressive of organic disease of the lungs, liver, or spleen.

The crystallized sediments are generally produced under the influence of a luxurious, indolent life, attended with dyspepsia, flatulence, acidity, and constipation of the bowels, with disorder of the cutaneous secretion.

In the treatment of this affection, it is important to ascertain, if possible, the causes by which it has been induced. It may be assumed, from what was previously stated, that these deposits are all dependent upon the retention in the system of nitrogenous principles, which, in consequence of derangement of the cutaneous and other emunctories, are obliged to pass off by the kidneys. The causes which may conduce to this result are—1st. Imperfect assimilative action; 2dly. The use of unwholesome food and drink; 3dly. Defective oxygenation of the blood from disorder of the lungs and skin; 4thly. Congestion, irritation, or inflammation of the urinary apparatus.

The first indication is to improve and invigorate the state of the digestive organs; 1st, by attention to the patient's diet, and, 2dly, by a proper regulation of his bowels. As a general rule, no articles of food should be permitted that are known to disagree. All kinds of pastry, fresh bread, and oily, fatty, and saccharine substances, should be interdicted. Boiled fish, raw oysters, and the white meats may be used in moderation once a day. For breakfast and supper, the latter of which should always be very light, brown bread, dry toast, or soda biscuit, with a small quantity of butter, and a cup of black tea, will generally be sufficient. At dinner, green

vegetables and ripe fruits may be indulged in, provided they do not impede the digestive process, or create flatulence and acidity. They promote the peristaltic action of the bowels, and furnish the urine with alkaline matter, thus preventing the deposit of gravel or lithic acid. Beef, pork, and mutton, if used at all, should be taken very sparingly. An important rule is to masticate as thoroughly as possible, to eat slowly, and not to overload the stomach, or overtask the powers of this organ. Coffee, beer, and alcohol should be eschewed. If the patient has been accustomed to the use of wine, he should either be obliged to discontinue it entirely, or limit himself to a little dry sherry or Madeira at dinner, although brandy and gin are far preferable. Hard water must be avoided. Some mild aperient, as blue mass and rhubarb, should occasionally be given to regulate the bowels. Active purgation is rarely required or proper. When there is much acid in the stomach and bowels, Castile soap may advantageously be united with the cathartic medicines.

Exercise should be taken at stated periods, in the open air, on foot, on horseback, or in a carriage. A valuable rule is never to carry it to fatigue, or to take it immediately after a meal.

It is a matter of primary importance to maintain the skin in a habitually clean and pure condition. In warm weather, sponging with cold water, either simple, or impregnated with salt, mustard, or alcohol, and followed by dry frictions, should be used, and, provided there is no contra-indication, the same plan may be pursued in winter. Cold ablutions are more invigorating than warm. They are, in fact, to the external surface what cold air is to the lungs. Nevertheless, a warm bath is occasionally highly beneficial, especially during a fit of the gravel.

The body and bedclothes should be frequently changed and aired, the skin should be protected both summer and winter with flannel, and the patient should avoid exposure to cold.

When the lithic deposit is connected with a gouty or rheumatic diathesis, recourse must be had to colchicum, preceded and accompanied by mercurial cathartics. Not unfrequently it is necessary to administer mercury in alterative doses until slight ptyalism is produced.

When tonics are required, the best articles are quinine, iron, and mineral acids, particularly the nitric and hydrochloric. The vegetable acids are also beneficial. Both kinds may be exhibited, either alone, or in combination with some of the vegetable bitters.

Bicarbonate of soda and of potassa, either alone or together, may be given to relieve acidity. The best time of exhibition is about an hour after meals. Phosphate of soda and ammonia, biborate of soda, liquor potassæ, and benzoic acid, are also valuable remedies.

Irritation of the urinary organs, especially if inflammatory, may be relieved by the application of leeches, cups, and blisters to the lumbar region, sacrum, or perineum. The warm bath will also be useful, and anodyne injections rarely fail to afford prompt relief.

Opiates have a happy effect in controlling the excretions in question, often curing the milder, and mitigating the distress in the more severe, forms. Morphia, lupulin, and hyoscyamus, are the best articles of this class. When the skin is disordered, Dover's powder may be administered.

2. The *oxalic deposit* holds, in point of frequency, an intermediate rank between the lithic and phosphatic, to the former of which it is closely allied. It occurs in the form of a white, glistening powder, insoluble on the addition of heat, acetic acid, and liquor potassæ, but soluble in hydrochloric acid, which is suspended in the urine, and manifests no disposition to precipitate itself, unless it can attach itself to some substance capable of constituting a nucleus. Under the microscope, this powder is found to consist of beautiful, transparent crystals, of an octohedral figure, with sharp and well-defined edges and angles, as in fig. 519. Occasionally, but rarely, they are shaped like dumb-bells, or like two kidneys united at their concavities, and so closely approximated as to appear almost circular. They vary much in size, but in general, they are exceedingly minute. If they are subjected to ignition on platinum foil, the oxalic acid is

Fig. 519.



Oxalate of Lime.

decomposed, and a small quantity of carbonate of lime is left, which is readily dissolved with effervescence on the addition of dilute nitric acid. Oxalic acid sometimes occurs as a distinct deposit, in the form of a small concretion resembling a hemp-seed, which may be retained in the bladder, and go on gradually increasing until it constitutes a mulberry calculus.

The formation of oxalic acid is favored by whatever has a tendency to impair the assimilative powers and to exhaust the vital energies. Hence, it is most commonly induced by errors of diet, or the use of unwholesome food and drink, excessive mental exertion, inordinate venery, exposure to cold, long continued suppression of the cutaneous perspiration, and injury of the spinal cord, brain, or sacrolumbar nerves. The immediate agency in its production is not yet entirely settled, but the experiments of Wöhler, Liebig, and Frerich render it more than probable that it is due to the oxidation of the uric acid. Certain articles of food, as rhubarb, sorrel, and tomato, also promote its appearance in the urine, as do also the frothy and sparkling wines.

The symptoms of this affection are such as generally indicate the presence of derangement of the digestive organs and of the nervous system. Dyspepsia often exists in a marked degree; flatulence is of common occurrence; the mind is often gloomy and despondent; the temper is fretful; the surface is exceedingly susceptible to external impressions; the extremities are almost constantly cold; the sleep is disturbed by disagreeable dreams; and the patient continually broods over his disease, having a thousand misgivings, and the most horrible forebodings; pain in the loins is a frequent symptom; the sexual power is usually much impaired; and the urine is often voided with uncommon frequency, as well as with more or less heat and smarting. As the disorder advances, the patient becomes excessively emaciated, and ultimately falls into a state of confirmed hypochondriasis. Serious pulmonary suffering is sometimes present, and in many cases the skin is covered with boils and scaly eruptions.

In the treatment of this disorder, the first thing to be done is to improve the general health. The diet should be regulated, and those articles which contain sugar and oxalic acid, and produce acidity and flatulence, should be carefully avoided. The body should be well protected with clothing, and the skin, washed daily with tepid salt water or some other stimulating fluid, thoroughly rubbed with a coarse, dry towel, or a flesh brush. In warm weather cold ablutions may be used. If there is much debility, tonics are indicated, such as quinine and sulphate of iron, in combination with capsicum and hyoseyamus. Sulphate of zinc, in the dose of one grain, two or three times a day, occasionally answers an excellent purpose. The mineral acids, as the dilute nitric and nitromuriatic, also possess valuable tonic properties.

3. The *phosphatic deposit* is characterized by its whitish or fawn color, by its pulverulent arrangement, by its solubility in dilute acids, and by its insolubility in ammonia and liquor potassæ. It presents itself under three distinct varieties of form, the triple, the calcareous, and the mixed, each of which demands succinct notice.

a. The *triple phosphate* consists of phosphate of ammonia and magnesia, on which account it is generally called the ammoniaco-magnesian phosphate. It commonly occurs in minute white crystals of a beautifully brilliant aspect, transparent or opaque, and remarkable for their sharp angles and edges. In their form, these

crystals exhibit great diversity, but in most cases they are right rhombic prisms, as in fig. 520. Occasionally they have a stellar, penniform, or foliaceous arrangement. They often float on the surface of the urine, especially if it is partially decomposed, and look like an iridescent film of grease. The urine which accompanies this deposit is preternaturally copious, pale, or whitish, of low specific gravity, ranging from 1005 to 1014, and precipitates the deposit on the application of heat. It has a faint, sickening smell, which soon becomes ammoniacal and offensive. In some instances of the affection the fluid is unnaturally dark, brownish or greenish-brown, decidedly alkaline, and loaded with dense, ropy mucus.

The triple phosphatic deposit very often alternates



with the yellow lithic or calcareous. Old persons are more subject to it than children and adolescents, and it is always associated with great disorder of the digestive organs. The patient is weak, irritable, and bloodless; the slightest exercise fatigues him, and he complains constantly of a dull, heavy, aching pain in the lumbar region. Overexertion, errors of diet, dyspepsia, severe courses of mercury, and excessive venery, are its most common exciting causes.

b. The calcareous deposit is composed of phosphate of lime, and occurs in the form of an impalpable powder, of a whitish, grayish, or drab color. The urine, as in the triple variety, is pale, copious, and of low specific gravity, and is readily decomposed by exposure to the atmosphere. The deposit is often accompanied by an inordinate secretion of mucus.

c. The mixed deposit, consisting of a combination of the two preceding, is very common. It is usually combined with mucus, which is often secreted in large quantity, and of a ropy, viscid character. The urine is fetid, pale, and abundant, depositing a thick, mortar-like sediment upon standing. The most common causes of this condition are, injury of the lower part of the spine, organic disease of the kidney and bladder, dyspepsia, long-continued bodily fatigue, mental anxiety, night watching, unwholesome food, and debilitating medicines. Patients thus affected are weak, flatulent, irritable, nervous, easily influenced by cold, emaciated, and of a gloomy, desponding disposition. The urine is voided more frequently than in health, and with more or less pain and scalding along the urethra. Pain in the loins is seldom wanting.

Carbonate of lime is occasionally found in small quantity in deposits of earthy phosphates, in union with alkaline urine. It generally occurs as an amorphous powder, but now and then in dense, crystallized circular stellæ. Its presence is readily detected with nitric acid, which dissolves it with effervescence.

In the treatment of this diathesis, the principal indications are, first, to improve the condition of the digestive organs; secondly, to acidify the urine; and, thirdly, to strengthen the system. To accomplish the first of these objects, it is necessary to regulate the diet, and administer mild aperients. Hard water should be avoided. Exercise should be taken daily in the open air, but it must never be carried so far as to induce fatigue. The skin should be frequently bathed.

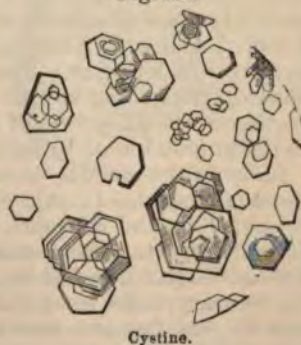
To fulfil the second indication, acids are required, of which the dilute nitric is the best. It may be administered by itself, in a large quantity of water, or, what is generally preferable, in union with hyoscyamus, black drop, paregoric, or infusion of opium. Anodynes can rarely be dispensed with, and are often of immense benefit, from the manner in which they allay pain and nervous irritation. In some instances the tincture of the chloride of iron proves useful. When the urine is rendered preternaturally acid, or when there is marked pyrosis, recourse must be had to soda, or soda and potassa, along with uva ursi and hop tea. All diuretics, properly so called, are injurious.

The third indication is fulfilled by the use of tonics, such as quinine, bark, and steel, a plain, but generous diet, exercise in the open air, and change of residence. A sea voyage is sometimes highly beneficial. Exposure to cold, irregularities of diet, and indiscretions of every kind, should be avoided, both during the actual existence of this diathesis, and for a long time afterwards, on account of the great tendency to relapse.

When the deposit depends upon lesion of the spinal cord, the internal use of strychnia, and counter-irritation, in the form of blister, issue, or the hot iron, will be beneficial. If inflammation of the bladder or kidney exists, it must be combated by the ordinary means.

4. The *cystine deposit*, a very rare, uncommon form, presents itself as a whitish sediment, consisting of colorless, hexagonal crystals of various sizes, impregnated with fatty matter, and often serrated at the edges. It is readily dissolved by the strong mineral acids, as well as by potassa and ammonia, and contains about 26 per cent. of sulphur. The urine which furnishes this sediment emits an odor similar to that of sweet briar, and is commonly found in connection with ill health, as dyspep-

Fig. 521.



sia, imperfect nutrition, and exhaustion of the nervous system. The fluid is sometimes acid, at other times alkaline. The quantity of urea and of uric acid is generally below the normal standard. The bladder is not irritable, nor is there much lumbar pain. Cystine forms the chief ingredient of the cystine calculus. The microscopic characters of this deposit are represented in fig. 521.

The chief means for correcting the state of the system upon which this deposit depends are the mineral acids, quinine, *nux vomica*, gentle exercise in the open air, mental relaxation, cold ablutions, and a generous diet, with a glass of sherry, Madeira, or whiskey at dinner.

STONE IN THE BLADDER.

Most urinary calculi take their rise in the kidneys, from which they descend into the bladder, where, if retained for any length of time, they gradually increase in size, and ultimately produce more or less obstruction. When they have a nucleus of uric acid or oxalate of lime, the probability is that they had a renal origin; but vesical, if it is phosphatic. Their progress along the ureter has already been described.

The disease occurs at all ages. I have met with it in very young infants, and cases have been related which render it highly probable that it is occasionally an intra-uterine affection. In my Treatise on the Urinary Organs are given the ages of 6042 cases of stone in the bladder, as occurring in England, France, and Russia, of which 2334 were observed from the first to the tenth year, 1079 from the tenth to the twentieth, 513 from the twentieth to the thirtieth, 353 from the thirtieth to the fortieth, 422 from the fortieth to the fiftieth, 536 from the fiftieth to the sixtieth, 587 from the sixtieth to the seventieth, 201 from the seventieth to the eightieth, and 17 from the eightieth to the ninetieth. Thus, it will be seen that more cases occur prior to the age of twenty than at all other periods together.

In attempting to form a correct estimate of the relative frequency of calculous complaints in children, adults, and old persons, we must not lose sight of the fact that many of the cases which fall into the hands of the surgeon are examples of long standing, extending, perhaps, through a period of many years. Thus, a man at forty may have contracted the disease at ten or fifteen. Moreover, it should be borne in mind that calculous diseases are more frequent, in certain countries, among children than among adults, and conversely.

It is not satisfactorily ascertained whether this affection is ever hereditary. Cases related by Civiale, Prout, and others, seem to warrant such an inference; but I have myself not met with any confirmatory evidence.

Stone in the bladder is very uncommon in females, owing, mainly, to their having a much shorter and more capacious urethra, which thus favors the excretion of any deposits that might otherwise form in the bladder. It has been alleged that this immunity is due to the fact that women are much less exposed to the exciting causes of the disease than men, a conclusion which is invalidated by the circumstance that at least one-third of all the cases of stone that are met with occur in boys before the tenth year, and, consequently, before they are subjected to any particular hardships.

The different varieties of the negro race of this country are much less subject to calculous diseases than the whites. I have ascertained from reliable statistics, founded upon 443 cases of stone in the bladder, occurring in Kentucky, Virginia, Tennessee, Georgia, Alabama, Louisiana, and Missouri, that the latter suffer three times as frequently as the former. The same fact disproves the idea, so much insisted upon by certain writers, that the use of corn bread and bacon, which constitute a large proportion of the daily food of the colored population, in the above regions, is favorable to the production of urinary calculi.

Stone in the bladder occurs in all parts of the world, although by no means with equal frequency. In this country, it is more common in Kentucky, Virginia, Tennessee, Ohio, and Missouri, than in any other regions. New England is remarkably exempt from it. The disease is sufficiently common in France, Austria, Hungary, Russia, England, and India. The inhabitants of Ireland, Spain, and Switzerland, on the contrary, suffer comparatively seldom from it. In Holland, calculus of the bladder is much less frequent now than it was a hundred years ago. The causes of these topographical differences in regard to the occurrence of stone in the bladder have not been determined. The great prevalence of the disease in limestone regions has long been familiar to observers, but whether the use of limestone water has really

any agency in its production, is still a mooted question. It is certain that it frequently occurs in freestone regions.

It has long been known that calculous diseases are much more common among the poor than the rich. Upon what this difference depends is not positively ascertained; the probability is, that it is mainly due to derangement of the digestive organs, engendered by the use of unwholesome food, by irregular habits, want of cleanliness, intemperance, and deficient clothing.

Occupation, no doubt, exerts an important influence upon the production of this disorder, but in what manner, or to what extent, is unknown. In Ohio, and the Southwestern States, especially Kentucky, Tennessee, and Alabama, the great majority of calculous subjects are common laborers, farmers, and mechanics. Seafaring people are remarkably exempt from urinary calculi, and a similar immunity seems to be enjoyed by soldiers.

Climate, also, exercises no little influence in the formation of urinary concretions. Thus, it is well known that the disease is most common in those parts of the world which are subject to frequent, great, and sudden atmospheric vicissitudes. In very cold and tropical regions it is exceedingly rare.

Certain kinds of food predispose to the formation of calculous disease. All articles having a tendency to create acidity and flatulence exert a deleterious influence upon the renal secretion, changing its properties, and promoting the deposition of earthy matter. Hot bread, in its various forms, frequently only half-baked, and generally very imperfectly masticated, is sufficient, if used for any length of time, to wear out the strongest stomach, and break down the most vigorous frame. A weakened digestion, with a sour and flatulent state of the stomach, constipation of the bowels, and an irritable condition of the brain, cannot by any possibility produce a healthy blood, any more than a morbid state of the blood can produce a healthy urine.

Various kinds of drinks exert an influence favorable to the formation of stone in the bladder. It has long been remarked in England that those districts in which cider is much employed are remarkably subject to calculous disorders. On the other hand, it is alleged that the use of Rhenish wine and of gin acts as a preventive.

The formation of stone in the bladder is remarkably favored by certain kinds of diseases, especially stricture of the urethra, chronic enlargement of the prostate gland, and organic affections of the bladder, ureters, and kidneys. Injury of the spinal cord, particularly when it involves the dorsolumbar portion of that structure, or the nerves detached from it, is extremely prone to be followed by phosphatic deposits; and it has long been known that gout and rheumatism are eminently conducive to the formation of uric acid calculi.

Physical Properties.—Most calculi have a distinct *nucleus*, around which the earthy matter accumulates and crystallizes. The nucleus may be formed of any substance, either solid or semisolid, whether generated in the urinary organs, or introduced from without. It generally consists of some saline matter of the urine, as uric acid, oxalate of lime, urate of ammonia, or phosphate of lime and magnesia. Inspissated mucus, lymph, hair, or clotted blood, may serve a similar purpose. In my private collection are specimens in which the concretions were formed around the tail-bones of a squirrel, an elm bougie, a piece of lead-pencil, and a bullet, the latter having been kindly presented to me by Dr. Robinson, of Warfordsbury, Pennsylvania. A similar case recently occurred to Professor J. C. Hughes, of Keokuk, in a man thirty-four years old, wounded four years previously. The concretion was as large as a hen's egg, and composed of phosphate of lime. In a preparation in the cabinet of Dr. Sabine, of New York, the nucleus consists of a piece of cork, as seen in fig. 522. Professor Van Buren informs me that he has a stone in the centre of which is an ear of wheat. Professor Billroth, of Vienna, in 1868, showed me two calculi, one removed from a man, the other from a woman, in each of which the nucleus consisted of a piece of paper. In the museum of the Royal College of Surgeons of Edinburgh is a concretion formed around a small nutshell. Professor Blackman has recorded a case in which the nucleus was an incisor tooth, evidently derived from an ovarian

Fig. 522.



Calculus with a Cork for a Nucleus.

cyst opening into the bladder; and in one observed by Mr. Curling, it consisted of human hair derived from a dermoid cyst situated between the bladder and rectum. Finally, the nucleus varies much in size, color, shape, and consistence; and, although generally single, it is sometimes double, triple, and even quadruple, probably from the aggregation of several concretions. In India, according to Dr. Carter, of Calcutta, oxalate of lime forms the nucleus of urinary concretions twice as frequently as in England.

The *number* of concretions is variable. In general, there is only one, but there may be several dozen, if not several hundred. The largest number I have ever found was fifty-four. Dr. Physick, in one case, met with upwards of one thousand, from the size of a partridge shot to that of a bean.

The mulberry calculus is almost always solitary; and the same is true, although not to the same extent, of the uric calculus. The phosphatic calculus, on the contrary, is not unfrequently multiple. When the concretions are numerous, they are generally proportionately small and smooth; when solitary, rough and comparatively large.

The *volume* of urinary concretions ranges from a hemp-seed to a goose's egg. In young subjects, and in recent cases generally, it is usually inconsiderable. The size of a urinary calculus, however, does not necessarily depend upon the period of its sojourn in the bladder, or the age of the patient. Occasionally, it increases very rapidly, so as to attain a large bulk in a very few months; and, on the other hand, it may remain small for many years.

The ammoniaco-magnesian and the fusible calculi are capable of attaining a very large size, while the uric, oxalic, cystine, xanthic, and fibrinous are almost always comparatively small, whatever may be their age, or the age of the patient. This fact is interesting in a practical point of view; because, by ascertaining the calculous diathesis of the sufferer, a tolerably correct idea may be formed of the volume of the stone under which he is laboring.

The *weight* of urinary concretions seldom exceeds a few drachms or ounces. Many examples, however, are recorded of four, six, eight, ten, twelve, fifteen, and even sixteen ounces. Deschamps gives one of fifty-one ounces.

The *consistence* of vesical concretions varies from that of semiconcrete mortar, chalk, or wax to that of stone. The hardest calculi are the oxalic and uric, which commonly emit a clear sound when struck with steel, and cannot be fractured without a considerable degree of force. Calculi, on the other hand, composed of ammoniaco-magnesian phosphate and phosphate of lime, are friable, and easily reduced to powder. The cystine and fibrinous calculi are quite soft, the latter scarcely equaling that of yellow wax. In what are termed alternating calculi, one part of the stone is commonly hard and compact, while another is soft and friable, if not pulverulent.

Calculi are occasionally composed of a mixture of sabulous matter and hair. Their formation is of rare occurrence, and they appear to consist, principally, of phosphate of lime and magnesia.

The *color* of these bodies is variable. The cystine and fibrinous calculi are of a yellow hue; the phosphatic, whitish or grayish; the oxalic, dark or blackish; the uric, rose, reddish, or brown.

Vesical calculi assume a great variety of *forms*. The circumstances which are chiefly concerned in producing this result are the action of the bladder, the friction which the concretions, when multiple, exert upon each other, and the nature of the nucleus. It is not unlikely that the chemical constitution exerts more or less influence upon the shape of a stone.

Vesical calculi are generally of an oval form, but they may be spherical, cylindrical, conical, spiculated, or even angular. Sometimes several are matted together, so as to resemble what, geologically, is termed a pudding-stone. The late Dr. Mussey showed me a very curious calculus, depicted in fig. 523, which had been removed after death from the bladder of a man who had long labored under disease of that organ. It is of a light-brownish color, and consists of a central portion and a number of distinct processes, each of which has a small cavity containing animal matter. The processes are remarkably rough, and some of them are nearly half an inch in length. Its composition is supposed to be oxalate of lime. Occasionally the concretion consists, apparently, of two parts, one corresponding with the bladder,

and the other with the urethra, as in fig. 524, or one with the bladder and one with the ureters.

The *surface* of these concretions may be smooth or rough. The oxalic calculus derives its common name from the irregularity of its exterior, which resembles that

Fig. 523.



Thoracic Calculus.

Fig. 524.

Urinary Calculus; *a* showing the Vesical, and
b the Urethral, Portion.

of a mulberry. The uric acid calculus is usually finely tuberculated. The surface is generally smooth when more than one concretion is present.

Chemical Properties.—The chemical constitution of urinary calculi varies very much in different localities. The oxalate of lime calculi, for example, in the Medical College at Calcutta, amount to 38.65 per cent.; in Guy's Hospital, London, to 22.59 per cent.; in the Royal College of Surgeons, to 14.75 per cent.; and in the Norwich Hospital, to 13.27 per cent. Uric acid calculi occur in smaller proportion in India than in England; and, as to phosphatic calculi, they reach only 3.36 per cent. in the former, while they amount to 10 per cent. in the latter. Dr. A. H. Hassall, of London, states that of 1000 calculi, the composition of which was ascertained by chemical analysis, 372 consisted of uric acid, either alone or mixed with small quantities of the urates and oxalate or phosphate of lime; 253, chiefly fusible concretions, of the earthy phosphates; 233 of varying layers of uric acid, oxalate of lime, and earthy phosphates; and 142 of oxalate of lime. The subjoined account includes all the varieties of concretions at present known.

The *uric calculus*, called also the lithic calculus, the most common species of all, is of a brownish color, inclining to that of mahogany, of a flattened, oval shape, occasionally finely tuberculated on the surface, but most generally smooth, but not polished, unless there are several concretions at the same time, and from the size of a currant to that of a hen's egg. If it be sawed, it will be found to consist of several layers arranged concentrically around a common nucleus, the laminae being frequently distinguishable from each other by a slight difference in color, and sometimes by the interposition of other ingredients. Water has but little action upon it; it is perfectly dissolved by caustic potassa, and disappears with effervescence in hot nitric acid, the solution affording, on evaporation to dryness, a bright carmine-colored residue. Before the blowpipe, it chars, emits a peculiar odor, and is gradually consumed, leaving a mere trace of ashes. Its specific gravity is about 1500. Fig. 525 shows the oval shape and finely tuberculated surface of the calculus, with its internal concentric layers.

Fig. 525.



Uric Calculus.

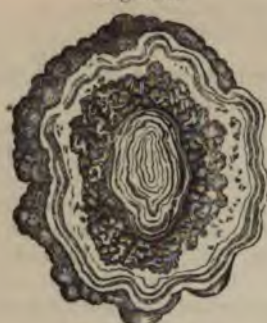
The *uro-ammoniac calculus*, a variety of the preceding, is principally observed in children, and is extremely rare. It is generally of small size, with a smooth surface, of a clay or slate color, and composed of concentric rings, which present a very fine earthy appearance when fractured. Much more soluble in water

than the uric calculus, it gives out a strong ammoniacal smell when heated with caustic potassa, and deflagrates remarkably under the blowpipe. Its specific gravity is about 1475.

The *oxalic calculus*, next in point of frequency to the uric calculus, is generally of a dark brown, olive green, or purplish color, rugged, spinous, or tuberculated on the surface, very hard, compact, and imperfectly laminated, seldom larger than a walnut, spherical, and always single. Under the blowpipe, it expands and effloresces into a white powder, while it dissolves slowly in nitric and hydrochloric acid, provided it be previously well broken up. In the alkalies, it is perfectly insoluble. Its fracture is splintery, and its specific gravity 1700. It is often called the *mulberry calculus*, from its fancied resemblance to the fruit of the mulberry, and consists essentially of oxalate of lime. Fig. 526 shows the external appearance and internal structure of this concretion.

A variety of mulberry calculus is known as the *hemp-seed calculus*, fig. 527, from some resemblance which it bears in color and lustre to that substance. It is always of small size, remarkably smooth, and generally multiple, often existing in considerable numbers.

Fig. 526.



Oxalic Calculus.

Fig. 527.



Hemp-shaped Calculus.

Fig. 529.



Ammoniacal-magnesian Calculus.

Fig. 528.



Phosphatic Calculus.

The *phosphatic calculus*, fig. 528, is of a pale brownish color, and of a loosely laminated structure, with a smooth, polished surface, like porcelain. The shape is mostly oval, and the size, although generally small, is sometimes very considerable. It whitens when exposed to the blowpipe, but does not fuse; and readily dissolves in hydrochloric acid, without effervescence. Composed essentially of phosphate of lime, it is extremely rare, as forming entire concretions, but frequently constitutes alternate layers with other matters. It is sometimes called the *bone earth calculus*, and occasionally contains small quantities of carbonate of lime.

The next species of calculus is the *ammoniacal-magnesian*, fig. 529, so called from the fact of its being composed of phosphate and ammonia and magnesia. It is of a white color, friable, and crystallized on the surface, looking a good deal like a mass of chalk, as its texture is without laminae; it easily dissolves in dilute acids, but is insoluble in caustic potassa; before the blowpipe, it exhales an ammoniacal odor, and at length melts into a vitreous substance. It sometimes attains an immense size.

The *fusible calculus* is a combination of the last two. It is of a white color, extremely brittle, leaves a soft dust on the fingers, is easily separated into layers, and presents, when broken, a ragged, uneven surface. It is insoluble in caustic potassa, but gives off ammonia; and, under the blowpipe, it is readily converted into a transparent, pearly-looking glass. This concretion is very common, and sometimes attains a very large size. It is frequently met with as an incrustation of foreign bodies. Its specific gravity is about 1300. Fig. 530 exhibits the outer appearance and internal structure.

The *cystic calculus* is very uncommon, small, tuberculated, of a waxy consistence, and of a greenish or tawny color. It consists of a confused crystallized mass, exhibiting, when fractured, a compact, radiating, lustrous structure. It burns with a faint bluish flame, exhales a strong characteristic odor of sulphuret of carbon under the blowpipe, dissolves easily in acids and alkalies, and is generally of an

oblong, oval shape. Its external and internal characters are shown in figs. 531 and 532.

The *xanthic calculus* is also extremely rare. Its texture is compact, hard, and laminated, its color cinnamon brown, its surface smooth, its volume small. In a

Fig. 530.



Fusible Calculus.

Fig. 531.



Fig. 532.



Cystic Calculus.

case, however, observed by Langenbeck, a concretion of this kind weighed nearly six drachms and a half. It dissolves very readily in acids and alkalies, and is gradually consumed before the blowpipe, emitting a peculiar fetid odor, splitting into fragments, and leaving a minute quantity of white ashes.

The *fibrinous calculus* is composed principally of the fibrin of the blood, a property to which it owes its name and character. It is of small size, of a spherical or oval shape, and of a brownish color. When dried, it shrinks, and loses some of its weight. It is of very rare occurrence.

Urostealith, a very uncommon form of concretion, first described by Heller, is of a rounded or oval form, soft, elastic, dark brown, and from the size of a hemp-seed to that of a hazelnut; when dried, it becomes brittle, and assumes a waxy or greenish-yellow appearance. It readily melts under heat, emitting a peculiar pungent odor, similar to that of benzoin, and is promptly dissolved by ether and solutions of caustic potassa, but is insoluble in boiling water. It consists essentially of fatty matter.

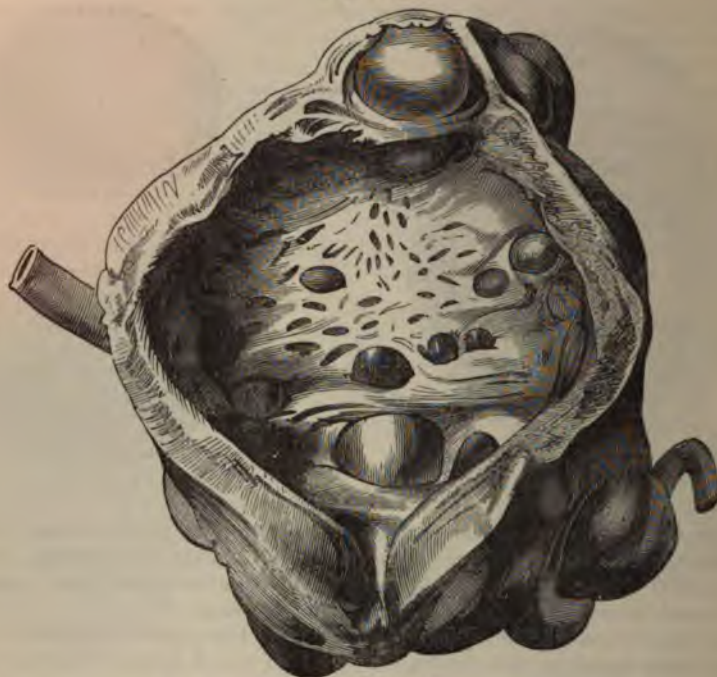
Situation.—Calculi lie generally loose within the cavity of the bladder, and are, consequently, liable to shift their position, not only with that of the viscus in which they are contained, but also with that of the body. Hence at one moment they may be at the bas-fond of the organ, at another at the neck, at another at its superior portion, at another at its sides, and at another, perhaps, at its anterior part, just above or behind the pubes. A knowledge of this variation in the position of these foreign substances is of no little importance in regard to the operation of sounding. Their most common situation, undoubtedly, is the bas-fond of the bladder, from the fact that this is the most dependent portion of the reservoir. In old subjects, affected with enlargement of the prostate, the concretion generally lies just behind this body, in a kind of pouch, hollow, or cul-de-sac. When this is the case, and the calculus is of large size, it may often be easily felt by the finger in the rectum. When the bladder is perfectly sound, the concretion, especially when the patient is in the erect posture, and the urine evacuated, rests against the neck of the organ, and sometimes even projects into the orifice of the urethra.

Cases occur in which the concretion is alternately loose and fixed. This may be owing to the existence of an abnormal pouch. The foreign body may also be arrested in the folds of the mucous membrane, in a depression behind the prostate, in the substance of this gland, in the orifice of the ureter, or in the mouth of the urethra.

Vesical calculi may become permanently *adherent*, attached, or fixed, as exhibited

in fig. 533, from a specimen formerly in the cabinet of Dr. Peticolas, of Richmond. This may occur in different ways, and under a variety of circumstances, of which the following may be mentioned as the most important: 1. An effusion of plastic matter. 2. The formation of an abnormal pouch. 3. The existence of a papillary

Fig. 533.



Encysted Calculi.

tumor or excrescence. 4. A bilobed state of the bladder. 5. The projection of the concretion into the ureter, or some other passage. 6. Its lodgment in the wall of the bladder.

Finally, the calculous matter, instead of being collected into a distinct concretion, is sometimes spread out in the form of a layer upon the bas-fond of the bladder. A layer of this kind, of considerable thickness, now and then forms around a papillary, erectile, or fibrous tumor of this organ. When the calculous matter presents such an arrangement, it grates under the instrument, and may be distinctly felt through the rectum. When struck with the sound it emits a peculiar noise, not unlike that of a cracked pot. I have seen several specimens in which this lamelliform arrangement coexisted with separate calculi.

Symptoms.—The symptoms of stone in the bladder may conveniently be divided into the rational and physical, or into local and general, according as they affect the urinary apparatus or the system at large.

The rational symptoms are: 1. Pain in making water, especially when the last drops are being expelled, felt both in the bladder and the adjacent parts. 2. A sense of weight and uneasiness in the pelvis, anus, and perineum. 3. Frequent micturition. 4. An occasional interruption of the stream of the urine. 5. Pain and itching in the head of the penis, with smarting and pricking sensations in the urethra, particularly at its orifice. 6. Enlargement of the penis and elongation of the prepuce. 7. Occasional priapism, with or without sexual desire. 8. An increased secretion of mucus from the lining membrane of the bladder, not unfrequently mixed with pus. 9. A bloody state of the urine. 10. Incontinence of urine. 11. Prolapse of the anus. 12. Sympathetic suffering. 13. Noise furnished by the calculi knocking against each other in the bladder. These symptoms usually come on gradually, and a considerable period often elapses before the patient is led to suspect the real nature of his condition. This is especially the case when the general health is good, and the bladder perfectly sound.

The constitutional symptoms of urinary calculus are exceedingly variable. In general, however, the suffering is much less than might, at first, be supposed. In children, in particular, the distress is often entirely local, the system taking little, if any, cognizance of the affection. In a great majority of the children whom I have cut, upwards of fifty in number, the general health was excellent, as was proved by the state of the countenance, appetite, and bowels, and the absence of fever and disorder of the secretions. Very often, indeed, the patient is, to all appearance, perfectly well. His cheeks are rosy, and he is fat and plump, as if nothing ailed him. Occasionally, however, he suffers very much, perhaps at a very early stage of the disease, and the distress goes on progressively increasing until the health is completely wrecked. Adults and elderly subjects are, as a general rule, much less tolerant of urinary calculi than children; the system soon gives way, the appetite and strength decline, and the features are strongly denotive of the vesical disease.

Lesion of the associate organs, of course, always increases the constitutional suffering. This is particularly true of disease of the kidneys. Whenever these structures are seriously implicated, the general health rapidly declines, and the patient, if not timeously relieved, gradually sinks under his complicated disorders. Disease of the bladder, as ulceration, hypertrophy, or chronic inflammation, never fails to aggravate the constitutional symptoms. Persons of a nervous, irritable temperament suffer more severely than the cold and phlegmatic. The nature of the concretion also exercises an important influence. Oxalic and phosphatic calculi usually cause more distress, both local and general, than any of the other varieties. Large stones, other things being equal, occasion more suffering than small, rough than smooth, multiple than single.

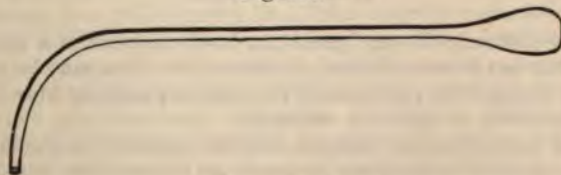
The most important general symptoms are, gradual failure of the health, disorder of the digestive organs, as flatulence, acidity, and irregularity of the bowels, derangement of the secretions, depression of spirits, loss of flesh and strength, and a remarkable susceptibility to atmospheric vicissitudes. The pulse is small, irritable, and abnormally frequent; the extremities are habitually cold; and the skin, dry and husky, exhales a peculiar urinous odor. Now and then, without any assignable cause, or under the effects of treatment, the symptoms, both local and general, temporarily disappear, to return subsequently, perhaps, in an aggravated form.

Calculus of the bladder occasionally produces epilepsy, as in an interesting case reported by Dr. John Duncan, of Scotland. The patient, a boy, five years old, had been suffering all his life from dribbling of urine, pain in the bladder, and other symptoms of stone. For upwards of two years he had frequent attacks of epilepsy, which continued, with more or less severity, until about a fortnight after he was lithotomized, when they permanently disappeared.

Physical Signs—Soundiny—Diagnosis.—When the symptoms above described are all present, or even when several of them are absent, there is a strong probability that the patient is laboring under stone of the bladder, and this probability is converted into certainty when the surgeon is able to feel and hear the foreign body. Nevertheless, cases occasionally occur, in which, notwithstanding the existence of both rational and physical signs, no concretion is to be discovered.

Sounding consists in introducing into the bladder an instrument shaped like a catheter, either solid or hollow, with which the cavity of the organ is explored. The instrument itself is called a sound.

Fig. 534.



Ordinary Sound.

Sounds vary in their construction, in their size, and in the materials of which they are composed. The best are solid, well polished, and made of steel, with varying degrees of curvature, as in figs. 534, 535, and 536. For an adult, the length from one extremity to the other should be about twelve inches, of which two inches and a

half should be allowed for the handle. Children, of course, require a shorter instrument. Generally speaking, a sound of moderate diameter is preferable to one of large size, as it is more easily moved about in the bladder. The vesical extremity or beak should be rounded off, not conical or pointed, so that it may not be arrested by the irregularities of the urethra. The curved portion should not, as a general rule, exceed three inches, and should form an angle of about 45° with the straight portion. The handle of an adult sound should not be less than two inches in length, by one inch and an eighth in width; it should taper somewhat towards the stem of the instrument, be about a line in thickness, rounded at the corners, and well polished. Every lithotomist should be provided with several sounds, of various sizes and curvatures.

A short time before the operation, the bowels should be well cleared out with castor oil, or a purgative enema, in order that there may be no obstruction in the rectum.

The bladder, at the time of the exploration, should contain from three to five ounces of urine; or, if it be too irritable to retain that quantity, or if the patient has urinated inadvertently, the requisite distention should be produced by the injection of tepid water, through a silver catheter, which may then be used as a sound, care being taken to stop up its orifice, to prevent the regurgitation of the fluid. An excellent substitute for the catheter is the hollow sound, represented in fig. 535, which

Fig. 535.



Hollow Sound.

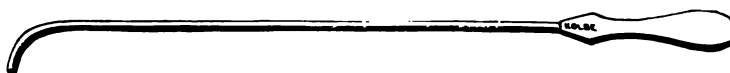
permits the gradual escape of the urine, thereby, in complicated cases, greatly facilitating the detection of the calculus.

During sounding, which should always be performed with the greatest possible care and gentleness, the patient should lie upon his back, with his head and shoulders somewhat elevated, and the lower extremities slightly flexed and separated, to relax the abdominal muscles. Adults are sometimes examined in the erect posture; children never, except under particular circumstances. The surgeon comports himself precisely as in catheterism.

Frequently the sound encounters the stone the moment it enters the neck of the bladder; should this not happen, it must be passed farther in, and moved about in different directions until the object is accomplished.

The pubic surface of the bladder can be reached only by an instrument with a very long curve, not unlike that of an English S. Very frequently the stone cannot be felt, in consequence of its lying in a pouch in the bas-fond of the organ, just behind the prostate. When this is the case, the index-finger of the left hand, properly oiled, is introduced into the rectum, and the foreign body pushed forwards against the

Fig. 536.



Abruptly-curved Sound.

sound. When the difficulty is very great, an instrument with a short, abrupt curve, as in fig. 536, which can be moved freely in every direction, may be used. Sometimes it is necessary to change the position of the patient, making him lie on his side, sit or stand, bend forwards, or raise his buttocks.

The crying and struggling of children may be quieted by the use of chloroform, which I am in the habit of employing in nearly all cases of the kind, both for the purpose of preventing pain, calming the patient's mind, and soothing the bladder.

The noise and sensation communicated by sounding are peculiar. The noise is a sort of click, clink, or clear metallic resonance. It is in the highest degree valuable as a diagnostic sign. It may often be perceived at a distance of several yards from the patient. Some surgeons, in order to render it more distinct and satisfactory, attach a flexible stethoscope, or a sounding-board of light, compact wood, to the

handle of the instrument; but I have myself never found any need of such an expedient. Mr. L'Estrange, many years ago, devised what may be called a reverberating sound, consisting of a small circle of light wood, in the form of a little drum, mounted on a stem, which, fastened to the ordinary instrument, affords a more accurate appreciation, both by the ear and finger, of the material struck, than any other contrivance. A grating, rubbing, or friction sensation is sometimes distinguished, but this is rather indicative of a fasciculated state of the bladder, a morbid growth, or an incrustated condition of the mucous membrane than of the existence of stone.

Patients are often brought to the surgeon from a distance to be lithotomized. When this is the case, they should not be sounded until they have recovered from their fatigue; nor should the operation be performed during or immediately after a "fit of the stone." The system should be prepared for the operation. From neglect of this precaution, patients are often subjected to much suffering, and there is no doubt that life has been repeatedly sacrificed in this way. I have myself in a number of instances witnessed very serious effects from this kind of indiscretion; and Sir James Paget states that he has known death to follow the mere sounding for stone in not less than six cases.

When the stone is very small, or the feel and noise elicited are very feeble, recourse may be had to auscultation, the stethoscope being applied either to the pubic region, to the sacrum, or to the perineum, while the sound is moved about in the bladder.

Sounding enables the surgeon not only to detect the presence of a stone, but frequently furnishes important data in regard to its bulk, situation, and consistence, and as to whether it is single or multiple, rough or smooth, loose or attached.

Another object in sounding is to ascertain the condition of the urinary apparatus. This can frequently be accomplished in no other manner. The capacity of the organ, and the amount of its sensibility or tolerance may thus be determined; and pretty accurate ideas may also generally be formed of the state of its inner surface, as to whether it is smooth or rough, ulcerated or fasciculated, incrustated with lymph or sabulous matter, or studded with papillary, fibrous, or other morbid growths. The passage of the sound along the urethra enables us to judge whether this tube is healthy or diseased, contracted, changed in its direction, or obstructed by foreign matter. The condition of the prostate gland is best determined by the finger in the bowel. The anus and rectum should always be carefully examined.

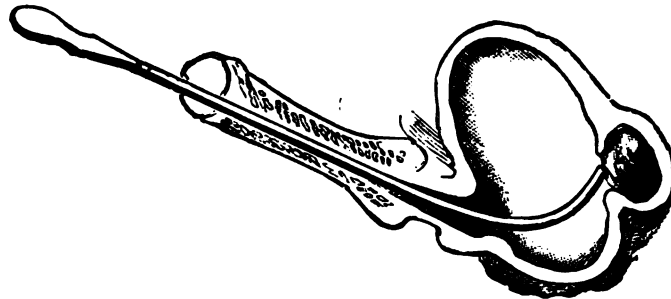
Although sounding is the only certain mode of detecting the presence of a stone, it is by no means free from error, as is proved by the fact that many a poor patient has been subjected to all the pains and perils of lithotomy, when the bladder was perfectly free from everything of the kind. I am cognizant of at least half a dozen cases in which this mistake was committed. The circumstances which may give rise to it differ very much in their character, some being dependent upon the bladder itself, others upon the neighboring parts, as the prostate gland, rectum, uterus, vagina, and pelvic bones. Mere irritability of the bladder, attended with a frequent desire to void the urine, may lead to the supposition of the existence of stone, and if the surgeon, anxious for the eclat of an operation, should, in such an event, strike his sound against a mass of impacted feces, a projecting sacrum, or a morbid growth in the bladder or pelvis, he might very easily deceive himself. The greatest possible circumspection should, therefore, always be used in sounding; the operation being, if necessary, performed again and again, until it is perfectly certain that there is or is not a stone.

On the other hand, it is well known that there may be a stone in the bladder, and yet the surgeon be unable to detect it by sounding, aided, perhaps, by all the auxiliary means at his command. This failure has frequently occurred even when the concretion has been uncommonly large, and when the operation has been repeatedly performed with the greatest care and skill, as well as varied in every possible manner. Want of success has sometimes attended even when the calculi were multiple. Again, it has happened that a stone has been promptly detected in a first sounding, and, perhaps, not at all, or only after much trouble, in a subsequent one. Or the reverse of this may occur, that is, the concretion may elude the instrument in a first and second sounding, but be always readily detected afterwards. It is with sounding as with everything else; to perform it well requires great tact in the use of instruments, a perfect knowledge of the anatomy of the urinary apparatus, and a degree of experience which multiplied observations alone can supply. The want

of success, however, in this operation, is not confined exclusively to the young, the ignorant, or the unskilful. Men of the most consummate dexterity have occasionally failed in detecting a stone, when a stone really existed.

Of the various circumstances which may prevent the detection of urinary calculi, some relate to the stone itself, some to the bladder, and some to the neighboring and associated organs. Thus, the foreign body may be very small; or there may be too much or too little water in the bladder during sounding; or it may be encysted, as in fig. 537, or lodged in a cul-de-sac, at the bas-fond of the bladder, just behind

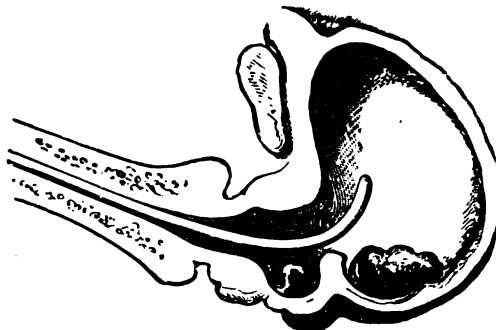
Fig. 537.



Sounding for Stone in Sacculated Bladder.

the prostate gland, as in fig. 538, when it will escape detection unless the beak of the sound be reversed. Sometimes, again, the concretion lies in a dilated ureter, or in a pouch in the prostate gland itself.

Fig. 538.



Sounding for Stone in Enlarged Prostate.

Pathological Effects.—Although the formation of vesical calculus is the immediate result of a morbid condition of the urinary secretion, the bladder and its associate organs are generally diseased, to a greater or less extent, in the progress of the affection. The primary impression is probably always made upon the viscus in which the concretion is confined; but the irritation which its protracted presence there induces is gradually reflected upon the other portions of the apparatus, awakening in them, in the first instance, important sympathetic actions, and, ultimately, serious structural lesions.

One of the first effects to which the foreign body gives rise is inflammation of the mucous coat of the bladder, as indicated by a frequent desire to make water, spasmodic pains in the lower part of the pelvis, and an increased secretion of mucus. Thickening of the lining membrane with increased vascularity, and the development of granulations, is another consequence; and, the irritation extending to the different coats of the bladder, hypertrophy of the organ may take place. A diminution in the size of the bladder is not usual even in young subjects, but is much more common in old persons, who have labored for years under the continued irritation of a calculus. Ulceration of the mucous coat sometimes occurs. It is most frequently observed at the neck and bas-fond of the organ.

One of the most distressing accidents which occasionally take place, during the

progress of this disease, is perforation of the bladder, followed by the partial, if not the complete, escape of the stone, and the formation of a fistule. When it is accompanied by extravasation of urine into the surrounding cellular tissue, it may terminate fatally in a few days, or lead to violent inflammation and suppuration, inducing death at a more distant period. If the patient survives any length of time, the concretion becomes gradually encysted, or it may even eventually be discharged externally by ulceration.

The urethra rarely suffers except in its prostatic portion, which may be unnaturally red, inflamed, hypertrophied or attenuated. The prostate gland soon becomes diseased. It gradually increases in volume and density, sometimes enlarging in every direction, impeding the flow of urine, augmenting the pain and spasm of the bladder, and even producing serious pressure upon the rectum. Ulceration, abscess, and sloughing may follow from the constant and excessive irritation. In some instances the prostate is greatly diminished in volume, or converted into a cavity, nearly equal to that of the contracted bladder itself, and capable of lodging a calculus of considerable size.

The ureters are frequently inflamed and thickened, sometimes ulcerated, and now and then enlarged, or enlarged at one place, and contracted at another.

The kidneys seldom entirely escape. In the worst forms of the malady, it is not unusual to see one of them converted into a large pouch filled with purulent matter, or turbid urine. In rare cases Bright's disease is present.

Abscesses and fistules occasionally form in the perineum. Prolapse of the anus may take place, attended with relaxation of the sphincter muscles, inflammation and thickening of the mucous membrane, and hemorrhoidal tumors. The excessive straining sometimes leads to the formation of hernia of the groin.

The orifices of the seminal ducts are, in many cases, dilated, or otherwise affected, and the ducts themselves may be variously altered. The seminal vesicles are sometimes atrophied, or diminished in volume and changed in structure.

A calculus of the bladder has sometimes obstructed parturition, and required extraction before the labor could be completed. In one such case the woman died undelivered because the nature of the difficulty was not determined during life.

Finally, when a number of calculi coexist, some of them may occasionally break spontaneously in the bladder, by striking forcibly against each other, as when the patient is running very fast, or even, perhaps, simply from the violent contraction of the bladder upon its contents. The occurrence, which is occasionally witnessed at a very early age, as in two cases observed by Southam, of course, implies extraordinary brittleness of the concretions, which is probably due to the decomposition of their cementing mucus. The oxalic calculus is not susceptible of such a change, of which a good illustration is afforded in fig. 539.

Prognosis.—The prognosis of this affection is variable. The only reliable treatment is removal of the concretion by operation. If it is permitted to remain, it generally steadily increases in bulk, and ultimately leads to serious organic disease of the bladder, prostate gland, ureters and kidneys, which causes not only a great deal of suffering, but imperils life by its long-continuance, the patient being finally worn out by hectic irritation. The period at which death occurs ranges from eighteen months to ten, fifteen, twenty, and even thirty years.

Fig. 539.



Calculus Breaking Spontaneously, and Causing Death by Inflammation.

TREATMENT OF STONE IN THE BLADDER.

A small calculus is sometimes extruded spontaneously, especially when the bladder, crowded with urine, contracts upon its contents with unusual vigor. Such an event is, of course, much more likely to happen in the female than in the male, owing to the difference in the length and dilatability of the urethra. Cases have

occurred in which riddance was effected by ulceration of the bladder, the concretion passing off by the rectum, vagina, perineum or hypogastrium.

Spontaneous fracture of a stone in the bladder is always fraught with danger, as the fragments, by their jagged edges and rough surfaces, must inevitably cause severe irritation, speedily followed by violent cystitis and death. In some cases, the patient perishes from peritonitis, or, if he survives the immediate effects of the accident, the bladder may give way by ulceration, and he may lose his life from extravasation of urine. Occasionally a sharp, irregular fragment is impelled into the urethra, causing retention of urine, or the obstruction may be produced by the presence of coagulated blood, poured out by the vessels of the irritated bladder.

When a calculus breaks spontaneously in the bladder, no time should be wasted in idle attempts at palliation; the only effectual remedy is lithotomy, and the sooner this is performed the more likely will the patient be to do well. The operation should be resorted to even when there are already well marked evidences of cystitis, although the chances of recovery will then be proportionately diminished.

The treatment of stone in the bladder necessarily divides itself into medical and surgical, of which the former is, in general, merely palliative, although frequently of paramount importance, whether it be considered only in reference to the temporary comfort of the sufferer, or as a means of improving his health, with a view to his relief by an operation.

1. MEDICAL MEANS.

Persons affected with stone in the bladder do not always find it convenient to submit to the operation of lithotomy or lithotrity, and it, therefore, becomes a matter of great importance to render them as comfortable as their circumstances may admit of. By attention to the general health, as regulated by food, drink and exercise, much may be done to allay local suffering, and to make the patient almost forget his disease. A concretion, which may have been a source of great distress for years, may, by appropriate and well-directed treatment, become a comparatively harmless tenant of the bladder, and thus convert a state of torture into one of Elysium. The improvement thus produced has sometimes lasted many years, although, in general, it is comparatively short. A consideration of these circumstances has led to a belief, not altogether unfounded, that urinary concretions are sometimes dissolved in the bladder, and voided along with the urine. Hence certain remedies, supposed to be endowed with this property, have received the name of lithontriptics or solvents and disintegrators of stone. Much of what might be said under this head has been anticipated in the article on the different calculous deposits.

It is hardly necessary to remark that a due regulation of the *diet* is of the first importance in the treatment of stone in the bladder. Without entering into details, it may be observed, in general terms, that the diet should be simple, easy of digestion, and yet sufficiently nutritious. Plainly roasted meats, boiled fish, mealy Irish and dry sweet potatoes, well boiled rice and hominy, soda biscuit, and stale wheat bread, with weak tea, or milk and water, are, ordinarily, the most suitable articles. Coffee, wine, fermented liquors, cider, and subacid fruits, with pastry, and the coarser kinds of vegetables, are to be eschewed. If the patient is feeble, or has been in the habit of employing liquor, a little French brandy, or, what is better, Holland gin, may be allowed at dinner and after exercise. Gin has a specific tendency to the urinary organs, and its use is occasionally attended with good effects. Some persons are greatly benefited by hop tea, beer, or malt liquors. Generally speaking, however, these articles produce more harm than good. All kinds of hard water must be abstained from as common drink. The patient should be well clad, avoid exposure to wet and cold, and refrain from rough exercise. In the winter, he should keep himself well housed, or reside, if possible, in a warm and genial climate. Sexual excitement must be carefully guarded against, for any indulgence of this kind is always sure to be followed by an aggravation of the complaint.

The urine must be kept in as neutral a condition as possible. If it be acid, alkalies are indicated; if alkaline, acids. Frequent examinations of the fluid are, therefore, necessary, in order that the remedies may be varied as the circumstances of each particular case may render it proper. It is worthy of remark that some patients are most benefited by alkalies, others by acids, even when the urine and the stone are both apparently of the same character. In my own practice, I have generally

derived most benefit from the use of alkaline remedies, whatever may have been the nature of the diathesis, or of the concretion.

The best alkalies in the treatment of vesical calculi are soda and potassa, in the form of bicarbonate, either alone, or variously combined with each other. I usually give the preference to the soda, for the reason that it seems to me to exert a more obtunding effect upon the mucous surfaces of the urinary passages. The best form of exhibition is a solution in a strong infusion of hops and uva ursi, in the proportion of thirty grains to the ounce, three or four times a day. The best period for using the medicine is about one hour after meals and at bedtime. Administered in this way it readily mixes with the ingesta, prevents the evolution of acidity and flatulence, and exerts a more controlling influence over the urinary secretion. The quantity of the salt may be gradually increased to forty, fifty, and even sixty grains, according to the tolerance of the stomach; and a good plan is to premit the use of it occasionally for a few days. Carbonate of potassa is sometimes employed alone, but its beneficial influence is always greatly enhanced by giving it in union with soda. *Liquor potassæ* now and then answers an excellent purpose in these cases, particularly in persons of a dyspeptic habit. It should be administered, largely diluted with water, in doses varying from twenty to forty drops, three times daily, or, what is better, under such circumstances, in combination with some of the simple bitters, as tincture of gentian, quassia, or cinchona. Some patients derive much relief from the free use of lime-water, castile soap, magnesia, or lye.

Marked benefit, sometimes of a permanent character, arises from the long-continued use of certain mineral waters. Of the various waters celebrated for their virtue of solving calculi and soothing the bladder, those of Vichy, in France, are the most remarkable, on account of the numerous cases that have been relieved by their employment. The Vichy waters contain a large quantity of free carbonic acid, and very nearly a drachm and a half of bicarbonate of soda in every thousand drachms of the menstruum, upon the presence of which their good effects, no doubt, mainly depend.

When the urine is decidedly alkaline, acids are indicated. Those usually employed are the nitric and hydrochloric, of which the former is preferable. The best form of exhibition is the dilute nitric acid of the shops, in doses of fifteen to twenty drops, three times daily, in a third of a tumblerful of cold water, sweetened with sugar.

Attempts have been made, from time to time, to dissolve urinary calculi in the bladder by means of injections of acid and other fluids, but the results have not been such as to encourage a repetition of the operation, now that the subject is so well understood. The same remark is true in regard to the effects of galvanic electricity, proposed by some French surgeon.

2. EXTRACTION OF CALCULI THROUGH THE URETHRA.

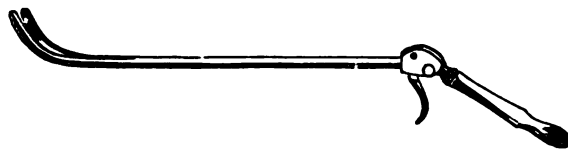
The fact that small calculi sometimes escape during micturition was long ago noticed by practitioners, and has been turned to good account by modern surgeons. When it is known, for example, that a concretion has recently descended from the kidney, its expulsion from the bladder may occasionally be effected by making the patient grasp the head of the penis, while he distends the urethra with urine; then, letting go his hold, he empties his bladder with all the force he can direct upon it by the action of the diaphragm and abdominal muscles. The water should be previously accumulated to the greatest possible extent, and, during its evacuation, the patient should lie upon his belly, or bend his body forward, to place the stone in the most favorable position for reaching the urethra. These attempts at extrusion are much facilitated by the prior dilatation of the tube by means of the bougie or catheter.

Efforts have been made, especially in recent times, to remove calculi entire from the bladder, through the urethra, by means of forceps. It was observed, long ago, that, during catheterism, small concretions became occasionally impacted in the eyelets of the instrument, which they followed upon its withdrawal. A circumstance so interesting and important was well calculated to arrest the attention of surgeons, and we accordingly find that they have taken full advantage of it. It was in this way that the late Mr. George Bell, of Edinburgh, had the good fortune to rid a patient of one hundred and fifty concretions. In performing such an operation,

a full-sized catheter, with two large eyelets, should be selected, and the bladder should be previously distended with water, so that, as the fluid runs off, the calculi may have a better chance of being forced into the tube.

Instruments have been constructed for the special purpose of seizing the stone, and removing it entire. Sanctorius, if not the first, was one of the earliest surgeons who busied themselves in this manner. He has described the operation with some minuteness, and has figured a pair of forceps which he contrived for performing it. Hales, Hunter, and others also invented instruments which have been greatly improved since by Sir Astley Cooper, and some of the French lithotomists. The forceps of the English surgeon, which are represented in fig. 540, and

Fig. 540.



Cooper's Stone Forceps.

with which he extracted upwards of eighty small calculi from one individual, consist of two movable blades, shaped, when closed, like a curved catheter. They are introduced in the ordinary manner, and are used at first as a searcher. When the stone is found, the blades are gently separated and expanded over it, when, being again shut, the instrument is carefully withdrawn. An index upon the surface of the instrument serves to show the size of the calculus, or, what is the same thing, the possibility of removing it entire. When the concretion cannot be extracted in this manner, it may, if not too hard or too large, be crushed, and disposed of piece-meal.

In performing this operation, it is important that the bladder should be perfectly free from irritation, that the urethra be previously dilated with the catheter or bougie, and that the forceps do not pinch the mucous membrane. If these precautions are neglected, serious mischief may follow. At least one instance is on record where death ensued, although the operation was executed by a competent surgeon, and the forceps were introduced only twice.

A small calculus has sometimes been entrapped and removed by a very simple procedure. Many years ago, an American practitioner, Dr. Calvin Conant, relieved a youth, fifteen years of age, by means of a silver wire, passed through a catheter, the vesical extremity of which was pierced by two holes, about a line and a half apart. The wire, which was very fine, elastic, and twenty inches long, was formed, upon its arrival in the bladder, into a loop, which was then moved about until the concretion was found and ensnared; the ends were next secured to the shoulders of the catheter, when both the instrument and stone were withdrawn.

3. LITHOTRITY.

It is not my intention in this place to enter into the history of lithotritry, or an account of the different steps by which, from humble and unsatisfactory beginnings, the operation has attained its present extraordinary degree of perfection. To Civiale is undoubtedly due the credit of the invention as now practised, his first notice of the operation having been published in 1824. Gruithuisen, a Bavarian surgeon, had already, in 1813, proposed to seize and perforate the stone by drilling; and Elderton, of Scotland, in 1819, formally recommended, for the same purpose, the use of a curved lithotrite.

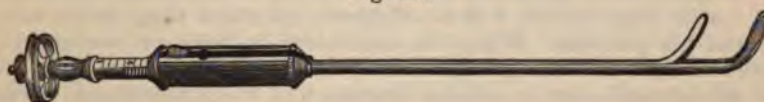
The procedure, as originally executed by Civiale and others, was denominated lithotritry, as it consisted in seizing, boring, perforating, or piercing the calculus. This name is still retained by the French and English surgeons, although the operation has been essentially modified. As performed at the present day, it consists in breaking, crushing, and pulverizing the foreign body, and is, therefore, more appropriately termed lithotripsy. In deference, however, to common usage, I shall employ the former name.

Instruments.—The instrument employed by Civiale, in his earlier operations, was

a silver canula, containing a steel tube, furnished with three branches, claws, or pincers. Within the steel tube, again, was a cylindrical rod, called the perforator, one end of which was fastened into a sort of crown with sharp teeth, to bore and break the stone into fragments. The perforator was moved during the operation by a steel drill-bow.

The trilabe of Civiale, and the instrument of Jacobson, of Copenhagen, at one time a good deal used, are now obsolete, having been replaced by the screw lithotrite, which combines several improvements, of which the most important are the curve, introduced by Baron Heurteloup, of Paris, the sliding movement, invented by Mr. Weiss, the celebrated London cutler, and the screw, suggested by Mr. Hodgson, of Birmingham, the action of which has been perfected by Charrière, Robert and Collin, Weiss, Coxeter, and others. The instrument, as now constructed, is remarkable for its simplicity, its lightness, its strength, and its adaptation to the end proposed. It is composed, as seen in fig. 541, of a shaft, sliding-rod, handle,

Fig. 541.



Weiss and Thompson's Lithotrite.

and two blades, and is from twelve to fourteen inches in length. The shaft terminates at its distal extremity in the female blade, while its proximal end constitutes the handle of the instrument. The sliding-rod, which moves in the longitudinal furrow of the shaft, and is provided, on its upper surface, with a scale for indicating the size of the stone, is curved at one end to form the male blade, while at the other is attached the power through which it is moved. In the instrument of Weiss, improved by Sir Henry Thompson by the addition of a fluted, cylindrical handle, thus admitting of great delicacy of manipulation, the crushing force is applied by means of a screw worked by a wheel. By sliding the button in the handle, the screw may be fixed or detached, thus converting the operation at once into the sliding movement, or the reverse. These actions are regulated in the instrument of Civiale by a movable disc, and by a trigger in that of Robert and Collin. Another form of power, devised, in 1834, by Sir William Fergusson, is that by the rack and pinion, depicted in fig. 542. It is useful when the concretion does not yield to

Fig. 542.

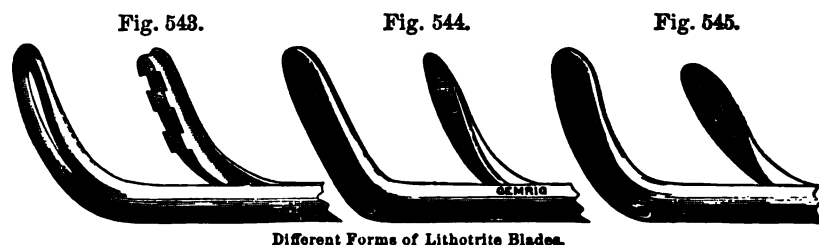


Fergusson's Rack and Pinion Lithotrite.

the pressure of the screw lithotrite, since the male blade is propelled onwards by short and sudden jerks, so as to imitate slight percussions, under the influence of which the stone is shattered. The shaft of this instrument is more slender than that of other lithotrites, an improvement which permits greater freedom of motion and nicety of exploration.

In the construction and choice of a lithotrite, great attention must be paid to the blades, in accordance with the object it is designed to fulfil. For crushing large and very hard calculi, an instrument with a fenestrated female blade, fig. 543, is essential to success, while for friable stones, which do not exceed one inch in diameter, the lithotrite with plain blades, improperly termed the scoop, fig. 544, of which the male is narrower than the female, may be employed; the instrument with blades of nearly equal width, fig. 545, being reserved for pulverizing fragments and diminutive concretions. In the first class of lithotrites, the surface of the male

blade is denticulated; in the others, it is simply roughened. Finally, the angle at which the shaft and blades are united should never exceed 120° , nor be less than 90° , the most efficient instrument, so far as power is concerned, being that in which it is somewhat greater than a right angle.



Different Forms of Lithotrite Blades.

Every operator should be provided with a number of lithotrites, of different forms and sizes, that he may be able, without difficulty, to adapt them to the varying circumstances of his patients. When the concretion is large, or uncommonly hard, the diameter of the shaft should equal 10 of the English catheter scale, while the combined lateral and antero-posterior diameters of the blades should measure 13, this ratio of difference in these parts being preserved as the instrument diminishes in size. For soft and medium-sized stones, the shaft may range between 7 and 10 for adults, and between 4 and 6 for boys.

In addition to lithotrites, the operator should be provided with Fergusson's scoops and Clover's evacuating apparatus, which are undoubtedly useful for removing fragments in cases of paralysis of the bladder and serious hypertrophy of the prostate gland, as well as long forceps and curettes, for the extraction of fragments arrested in the urethra.

Selection of Cases for Operation.—A proper selection of cases is a matter of the first importance in this operation, for it is not every calculus that admits of being crushed. The circumstances which are favorable to the procedure are chiefly a capacious urethra, a sound condition of the genito-urinary organs, the existence of a small, or medium-sized and comparatively soft, calculus, and a good state of the general health. These conditions being present, lithotripsy should be selected in preference to lithotomy for women and for males above the age of puberty, the latter operation being reserved for all cases below that period. Stricture of the urethra, enlargement of the prostate gland, or disease of the bladder, ureters, and kidneys are obstacles only when they exist in an aggravated degree. A recent stricture, which may be overcome by dilatation or rupture, ceases to be a contra-indication, while the operation is, of course, impracticable when the contraction is so great as to render the easy working of the lithotrite impossible. A soft, moderately and uniformly enlarged prostate is a complication which adds to the difficulty of seizing the concretion, and demands the employment of an evacuating apparatus, to effect riddance of the detritus; but ordinary hypertrophy of the gland becomes an obstacle only when it is associated with irritability of the bladder, or when it is extensive and assumes the mammillated form. Paralysis of the bladder is a decidedly favorable condition, as the sensibility of the mucous membrane is usually obtunded, thereby permitting a free use of instruments. The inability of the organ to expel its contents is compensated for by the removal of fragments with scoops and injections. The operation is inadmissible in the sacculated bladder, in cystitis, acute and chronic, conjoined with a large calculus, in ulcerated conditions of the bladder, in excessive morbid sensibility of the urethro-vesical mucous membrane, on account of the great susceptibility to systemic disturbance from instrumental contact, in morbid growths, in organic disease of the kidneys, and, finally, in persons of feeble health, the subjects of a hard or large concretion. The composition, size, and number of stones have an important bearing on the selection of cases for lithotripsy. In general terms, it may be said that all calculi, irrespective of their chemical nature, which are below one inch in diameter, and do not weigh more than one ounce, are favorable for the operation. The mulberry concretion is so firm and compact as to require a very considerable amount of force to break it, and the fragments are irregular, sharp, angular, and productive of irritation. When it exceeds one inch in diameter, the case is one for lithotomy, and, even when

smaller, a sound condition of the urethra and bladder is essential to a successful issue. Phosphatic and uric calculi above eighteen lines in diameter should, as a rule, be cut; and this is particularly true of the pure forms of the latter concretion, the fragments of which are as irritating to the bladder as those of oxalate of lime. Encysted, adherent, and multiple concretions are contra-indications, but the crushing of two or three small stones is as successful as that of pulverizing large fragments.

Preparatory Treatment.—Before operating, the system and the parts more immediately concerned should be subjected to a proper course of treatment. If the general health is good, and the bladder is laboring merely under the mechanical inconvenience produced by the stone, little, if anything, will be required beyond a few doses of aperient medicine, rest in the recumbent posture for five or six days, light diet, and the free use of diluent drinks. Should the reverse be the case, a more thorough preparation must be instituted. Under such circumstances, in addition to the ordinary means adverted to, it may be necessary to take blood from the arm, or by leeches from the perineum and the hypogastric region, especially if the patient is young and robust, and to employ the warm bath, bicarbonate of soda with hop and uva ursi tea, and anodynes by the rectum, along with washing out of the bladder, if there be much discharge of muco-pus. In this way we endeavor to subdue undue irritability, and restore the tonic of the bladder, so as to enable it to retain a few ounces of urine.

The next step is to dilate and subject the urethra to a course of preliminary training, to enable it to bear with impunity the necessary manipulations. This usually requires but a few days, and is best accomplished with a series of silver catheters, or highly-polished steel bougies, used, at first, once, and subsequently two or three times, in the twenty-four hours. If the meatus is unusually small, it should be enlarged with the bistoury. When the irritability of the urethra is so great that it is increased, instead of being obtunded, by the passage of instruments, as may happen in nervous, excitable persons, in whom such attempts are frequently followed by attacks of urethral fever, further interference in this direction should be desisted from, and the case be reserved for cutting. Chloroform ought generally to be avoided, except in children, as the operation is not attended with much pain. The patient's mind should be clear, in order that he may promptly inform the surgeon of any undue suffering that may arise.

Operation.—During the operation, the patient lies on a firm mattress, with the pelvis moderately elevated by a cushion, the thighs being separated, and the knees supported by pillows. The bladder should contain from three to four ounces of fluid, that quantity being insured by requesting the patient to retain his urine for an hour and a half previously to the sitting, or, in the event of the organ being empty, by the preliminary injection of tepid water. The surgeon, standing on the right side of, and with his back towards the face of, the patient, introduces the warmed and well-oiled lithotrite into the meatus, the penis being supported as in the ordinary operation of catheterism, the shaft resting on, instead of being grasped by, the fingers, and lying horizontally across the groin, and permits it, as it is being carried towards the middle line of, and in close proximity to, the abdomen, while the penis is drawn forwards, to find its own way, as it does by virtue of its weight, to the opening in the triangular ligament, its arrival at this point being denoted by impediment to its onward progress. The handle is then changed to the vertical position, through which manœuvre the beak engages in the orifice, traverses the membranous urethra, and glides on into the bladder through the prostatic portion, as the handle is depressed between the thighs. Force is inadmissible, the instrument, as it were, falling, rather than being passed, into the bladder.

The next step of the operation is to seize the stone. This may be accomplished in two ways. In the first method, originated by Heurteloup, and practised by Brodie,



Fig. 546.

Seizure of the Stone.

the handle of the lithotrite is elevated, and, while the male blade is withdrawn, the female blade is pushed forwards and pressed gently against the inferior fundus of the bladder, as represented in fig. 546, thereby making a conical depression, into which, and consequently into the separated blades, the tendency of the concretion is to fall. Should this fail, the operator endeavors to dislodge the calculus and coax it between the blades, by imparting slight concussions to the bladder by tapping the instrument with the fingers, or slapping the pelvis of the patient, the male blade at the same time being pushed onwards. In the second mode, now generally practised, the contact of the instrument with the bladder is effected in as gentle a manner as possible. Should the stone be felt on the introduction of the lithotrite, the jaws are inclined towards the opposite side, while the female blade is propelled forwards and the male blade withdrawn. Having been separated to the requisite extent, the blades are then turned towards the stone and closed. In this way, seizure is almost always readily accomplished. If the stone is not felt as the instrument enters, the jaws are maintained at the centre of the bladder, the male blade being drawn towards the operator, and inclined, first, to the right side, and then to the left, and closed, the axis of the shaft remaining unaltered. Should the stone not be caught, the blades are raised from the floor of the bladder by slightly depressing the handle, opened, turned horizontally to the left, and closed. This failing, they are again brought to the centre of the bladder, separated, inclined as before to the right side, and closed. If these manœuvres are properly executed, few stones will escape detection and seizure.

In enlargement of the prostate gland, in very corpulent persons, and in dealing with small concretions or fragments, the pelvis must be elevated from four to six inches, and lithotrites with short blades, in order that they may be used in reversed positions, be employed. Any of these conditions being present, the handle of the instrument is still farther depressed, and the blades, first brought into the horizontal position, inclined to the right, then to the left, and, lastly, completely reversed, the precaution being observed to separate them before turning. When the concretion, particularly if it be large, lies in a pouch behind the prostate, the male blade must be maintained steadily at the neck of the bladder, while the female blade is propelled onwards. If the male blade be withdrawn, under these circumstances, it will impinge against the stone, press it against the neck of the bladder, and thus defeat our object.

Seizure having been effected, the next step of the operation is the crushing of the stone, previously raised to the centre of the bladder, as shown in the annexed sketch, fig. 547, and firmly fixed by locking the screw and giving the wheel a gentle turn.

Fig. 547.



Position of Stone for Crushing.

The power being gradually increased, the stone is broken into several fragments, when the male blade is disengaged, drawn back, and the latter successively attacked, without altering the central position of the instrument. When the stone is soft or small, it may readily be crushed by propelling the male blade onwards by the palm of the right hand, the handle being steadily held in the left hand. In either mode, the operator should be satisfied with fracturing the concretion and crushing two or three of the coarsest fragments, the first sitting being limited to two or three minutes, lest grave local and constitutional disturbance follow. The subsequent sitting should not, if possible, exceed four or five minutes, as long crushings subject the patient to

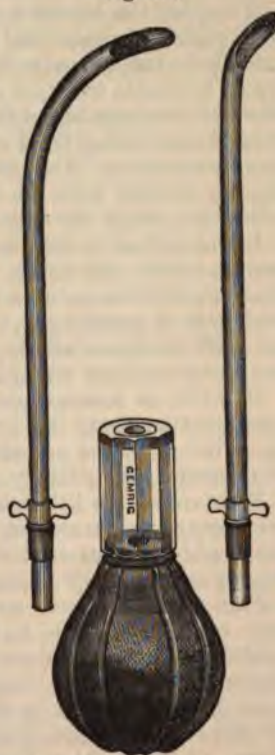
much future discomfort, if not positive peril. At the completion of each operation, the instrument is closed and withdrawn, care being taken that no large fragments remain impacted in its jaws, otherwise serious injury may thereby be inflicted upon the urinary passages. If the scale on the sliding-rod denotes such an occurrence, by returning the blades to the centre of the bladder, and making rapid alternate turns of the screw, the detritus may be forced through the opening in the female blade and by the sides of the narrow male blade. The inclusion of a moderate quantity of pulverized débris in the jaws, however, is not liable to be followed by accident if the urethra be capacious and non-sensitive; but, even under these favorable conditions, it is best to leave its evacuation to the efforts of nature.

After-treatment.—The subsequent treatment must be conducted on general principles, the great object being to allay irritation, both local and constitutional. On no account should the patient be permitted to walk to his home, as in the event of his being an out-patient. Every man subjected to the operation should be treated either at his own house or in the wards of a hospital. Under opposite circumstances, I have known the worst consequences to ensue, although not in my own practice. After the sitting, especially if it be the first, the patient is to be put to bed for a day or two, warmly wrapped up, and kept upon light diet, using, however, large quantities of diluent drinks. He should refrain from making water for several hours, and then perform the act in the recumbent posture. If much pain or spasm ensue, with frequent desire to empty the bladder, a large anodyne is given, either hypodermically, by the mouth, or by the rectum, hot fomentations are applied to the hypogastrium and perineum, and an infusion of uva ursi and lupuline, with bicarbonate of soda, or bromide of potassium, is administered internally. Retention of urine is relieved with the catheter. If peritonitis threaten, the antiphlogistic treatment, modified by the general condition of the patient, is carried to its fullest extent, aided by the liberal use of opium.

If no untoward symptoms arise, the operation may be repeated, with a lithotrite with plain blades, in from three to seven days, the succeeding sittings following at shorter intervals, and being prolonged as the bladder becomes accustomed to instrumental contact. The aim of these manipulations being the pulverization of the fragments, the more thoroughly this object is effected the less occasion will there be for a resort to evacuating catheters and washing out the bladder, which should, as far as possible, be refrained from. The most important part of the whole procedure, and one which requires great judgment, delicate touch, and manipulative skill, is the removal of the last fragments, for the smallest remaining particle will be certain to serve as the nucleus of a new concretion. Instead of pulverizing or waiting for the spontaneous discharge of the smaller particles, and with a view to abbreviate the operation, Sir William Fergusson uses his slender scoops for their extraction, his results sustaining this practice, which, up to 1867, embraced sixty cases, in some of which, however, the urethra was roughly handled. Other operators prefer to search for and thoroughly crush the last fragments with light lithotrites furnished with short, plain blades, and trust to the unaided efforts of nature for their discharge, a procedure, in my opinion, far preferable to the withdrawal of sharp, angular pieces in the jaws of the instrument, as this renders the patient liable to urinary infiltration and abscess, and the subsequent impaction of fragments in the urethra, from laceration of its walls.

In exceptional cases, as in hypertrophy of the prostate gland and paralysis of the bladder, in which the detritus cannot easily be discharged, a resort to evacuating measures is essential to success. Of the different apparatus for the removal of crushed fragments, the best is that of Mr. Clover. It is composed, as seen in fig. 548, of an India-rubber bottle, fitted to a glass cylinder, into which the evacuating catheter projects about one inch.

Fig. 548.



Clover's Evacuating Apparatus.

The latter are of various forms and sizes, the best being one provided with a lateral opening comprising one-half of its thickness, and one in which the concave surface of the vesical extremity is deficient, as represented in the sketch. The bottle, filled with warm water and attached to the catheter, through which the urine has previously been allowed to escape, is alternately slowly compressed and rapidly expanded, the return current bringing with it the fragments, which fall into the glass reservoir. As the opening of the tube is in contact with the vesical mucous membrane, the operation, if not conducted with great care, proves as annoying and irritating as that of lithotrity itself.

Accidents and Ill Effects.—The accidents and ill effects of this operation are—1. Hemorrhage. 2. Rigors and fever. 3. Retention of urine. 4. Contusion and laceration of the prostate and urethra. 5. Cystitis. 6. Perforation of the bladder. 7. Impaction of fragments of the stone in the urethra. 8. Peritonitis. 9. Purulent infection. 10. Atony of the bladder. 11. Renal irritation. 12. Orchitis. 13. Bending and fracture of the lithotrite. Some of these accidents are unimportant, others serious, if not fatal. Hemorrhage, rigors, retention of urine, cystitis, and prostatitis, should be treated upon general principles.

Perforation of the bladder, although uncommon, has sometimes happened in the hands of the most skilful operators. The accident, which is a most serious one, may be caused either by the instrument itself, or by a fragment of the calculus, a sharp corner of which may, perhaps, be pressed into the coats of the bladder as the lithotrite is withdrawn. However induced, the lesion is generally rapidly followed by infiltration of urine and death.

A fragment of the broken calculus may be arrested in the urethra, and, if sharp and angular, serious mischief may ensue. If it is situated far back, an attempt should be made to push it into the bladder, or, this failing, it should be removed by cystotomy; but, if it has advanced considerably forward, it may be removed with a curette or with the forceps, delineated in the section on foreign bodies in the urethra.

Purulent infection occasionally occurs, chiefly in old, enfeebled subjects. It is usually very stealthy in its character, and is nearly always fatal. Our principal reliance must be upon opium, tonics, and stimulants, with free incisions to afford vent to effused and pent-up fluids.

Atony of the bladder, as an effect of lithotrity, occurs chiefly in old subjects, from rude and protracted efforts at crushing. The irritation thus occasioned rapidly extends to the muscular fibres of the organ, which, crippled, if not completely paralyzed, is unable to expel either the urine or the fragments of stone, the retention of which becomes an additional source of suffering, both to the part and system, the great danger being from cystitis, accompanied with a low form of fever and excessive prostration. The proper remedy is riddance of the fragments. Sometimes this may be effected with the lithotrite, aided by the apparatus of Clover. When these efforts fail, relief must be sought by lithotomy.

Renal irritation, followed by suppression of urine, is a rare, but commonly a fatal, accident after lithotrity. It is most frequent in elderly, irritable persons, and is characterized by pain in the back, a quick, frequent pulse, intense thirst, and other evidences of prostration, along with typhomania. The treatment must be supporting, the chief remedies being quinine, opium, and milk punch, with cupping of the loins, and the use of the warm bath.

Orchitis, as a consequence of lithotrity, is uncommon: due to the extension of inflammation along the ejaculatory and deferential ducts, it is most liable to follow upon injury to the prostatic urethra, within a few days after the accident, and is to be treated upon ordinary antiphlogistic principles.

Fracture of the lithotrite has occurred, but is scarcely possible in instruments as constructed and tested at the present day. Should one of the blades be retained in the bladder, an attempt should be made to extract it with the forceps; this failing, the organ should be opened through the perineum.

Statistics and Results as Compared with Lithotomy.—No reliable statistics of lithotrity on a large scale have hitherto appeared. In 1856, Dr. Ivanvich, of Vienna, published the particulars of 100 cases of this operation, of which 13 died. Dr. Swalin, of Stockholm, has lost 7 out of 49 cases. Brodie performed the operation upon 115 cases—not, however, upon so many different patients—of which 9 died. Of 133 cases, in 122 individuals, of whom 12 were females, in the hands of Professor Porta, of Pavia, 24 proved fatal, 45 failed, 8 were abandoned, and 13 were lithoto-

mized. Dr. Keith, of Aberdeen, lost 7 out of 116 cases. Sir William Fergusson had had up to June, 1865, 109 cases, of which 12 died; and Sir Henry Thompson lost 13 out of 204 patients. Excluding the cases of Porta, who appears to have been very unsuccessful in this direction, these facts indicate 693 cases, with 61 deaths, or about 1 in $11\frac{1}{3}$. Of 723 lateral lithotomies between the ages of twenty-one and eighty-one, on the other hand, derived from English hospitals, and tabulated by Thompson, 150, or rather more than 1 in 5, were fatal. A comparison of the two operations in adults as practised by the same surgeon leads to similar results. Thus, of 116 cases of lithotripsy in the hands of Keith, 1 in every $16\frac{1}{2}$ died, while the rate of mortality of 160 cases of lithotomy was 1 in $4\frac{1}{2}$. Fergusson lost 1 patient in every 9 out of 109 subjected to crushing, and 1 in $3\frac{1}{2}$ out of 110 cases that were cut. That lithotripsy is an eminently successful procedure in picked cases is clearly shown by the valuable and highly instructive statistics of 204 consecutive operations performed by Sir Henry Thompson. The youngest patient was twenty-two years old, and the eldest eighty-four, the mean age being sixty-one years; 53 cases were above seventy years, and 126 were sixty years and upwards. Not a single operation was left unfinished, and the rate of recoveries was $93\frac{1}{2}$ per cent. The cause of death in six was nephritis, due probably to the explosion of preëxisting disease; in four acute cystitis in connection with a sacculated condition of the bladder, and in three pyæmia. Many of the subjects were in feeble health. One hundred and thirty-five of the calculi were uric acid and urates; sixteen were mixed; forty-seven were phosphatic; four oxalate of lime; one cystic oxide; and one pure phosphate of lime. With a few rare exceptions the stone weighed less than one ounce, and every case was successful in which it did not exceed the size of a small nut.

If the dangers of crushing and cutting be estimated by the weight of the calculus, it will be seen that the recoveries are still in favor of the former. Thus, of the 204 cases of Thompson, 13, or 1 in $15\frac{7}{10}$, perished, while of 529 cases of lateral lithotomy for stones weighing one ounce and under, tabulated by Mr. Crosse, 47, or 1 in $11\frac{1}{4}$, were fatal. The same is true even of median lithotomy, for which better results are claimed than for the lateral operation, the ratio of deaths after the former, according to Mr. Allarton, being 1 in 7 for adults, while that for lithotripsy, as above pointed out, is 1 in $11\frac{1}{3}$. These marked differences in the mortality of the two operations admit of no doubt as to the one which should be selected for adult males. The comparison, however, is scarcely a fair one, since it does not represent the actual state of affairs, the cases for lithotripsy having been selected, while those for lithotomy have been taken irrespective of complications.

For children and boys lithotomy should be the rule, crushing the exception. In this class of subjects the urethra is small, and the bladder very excitable, as well as, from its situation, unsuited to the operation, which is only permissible when the concretion is so small that it can be gotten rid of in one or two short sittings. Of 21 cases, in the hands of Guersant, 6 died, and 3 were subsequently cut. Of 62 operations at the Moscow clinic, 6 died, and 54 recovered, in twenty-four of which only one sitting was required. Thus, of 83 cases, 12, or 1 in 7, perished. From infancy to sixteen years, 1028 cases of lateral lithotomy, collected by Thompson, show 68 deaths, or 1 in 15, while the median operation up to the age of twenty, according to Allarton, gives only 1 death in every 27 cases, or, according to Mr. Williams, of the Norfolk and Norwich Hospital, 1 in 20 for the same epochs of life. Of 52 cases of lateral lithotomy in children up to the age of puberty, I have lost only one.

In estimating their comparative value, it is distinctly to be borne in mind that relapse is more frequent after lithotripsy than lithotomy. In the practice of Thompson it occurred once in every eleventh case, and in that of Civiale in every tenth. In the Norfolk and Norwich Hospital, on the other hand, stone recurred once in fifty-eight cases, and in the Luneville Hospital once in 116 cases of lithotomy. My own experience, which comprises one hundred and fifteen cases of the latter operation, has afforded me only one instance of recurrence. The frequent relapse after lithotripsy is doubtless due to the fact that fragments of the broken stone are so liable to be left in the bladder, which thus become, often in a very short time, the nuclei of new formations. In lithotomy, on the contrary, the concretion is generally removed whole, while any pieces that may be split off are either extracted at the time, or they are washed away subsequently by the urine as it flows through the wound, the patency of which, for a certain time, greatly favors this mode of clearance.

The results of lithotrity, like those of lithotomy, vary, no doubt, materially in the hands of different operators, according to the manner in which they select their subjects, the mode and skill with which they execute their manipulations, and the attention which they bestow upon the preliminary and the after-treatment. There is every reason, too, to believe that the mortality is much greater in hospital than in private practice. All things considered, the conclusion is inevitable that the procedure, in skilled hands and in selected cases, is decidedly more safe and satisfactory than lithotomy.

4. LITHOTOMY.

Lithotomy may be performed at any period of life, even in early infancy. Experience, however, has shown that the greatest number of recoveries takes place in children and in elderly subjects. Young adults and middle-aged persons are more prone to suffer from inflammation of the urinary apparatus, and perhaps, also, from erysipelas of the wound, and phlebitis of the neck of the bladder and prostate gland.

When a patient is about to undergo lithotomy, he should be subjected to a certain degree of preparatory treatment, in order to place him in the best possible condition to bear the shock and other ill effects of the operation. There is no doubt that much of our success depends upon the manner in which this is done. When the patient is in good health, he will seldom require anything more than a dose or two of aperient medicine, and abstinence from animal food, with rest in his room. Four or five days will, in fact, generally suffice to put him in a proper condition for the operation. But it is very different when he is in bad health; for then a more thorough course of preparatory measures is necessary. The secretions must be rectified, the bowels opened by mercurial and other cathartics, the diet regulated, and, in a word, all sources of excitement, local and constitutional, removed. Too much preparation, however, must be avoided. All serious lesions of the lungs, kidneys, ureters, bladder, prostate gland, and other of the more important viscera, forbid interference.

Lateral Operation.—Of the different operations for stone, the lateral, perineal, or infra-pubic, as it has been variously termed, is by far the most important, not only on account of its greater frequency, but also of the remarkable success which has hitherto attended it. In the description which I am about to give, I shall speak of it as I am myself in the habit of executing it, premising that this does not differ, in any essential particular, from the method devised and so happily practised by Cheselden and his disciples.

The design of the lateral operation is to make an opening on the left side of the perineum, extending from the surface of the skin through the neck of the bladder and the prostate gland, and large enough to admit of the easy extraction of the foreign body. It is usually described as consisting of three steps or stages. In the first, the surgeon divides the skin, the cellulo-adipose tissue, and the superficial fascia; in the second, the transverse muscle, the triangular ligament, and the membranous portion of the urethra; and, in the third and last, the prostate gland and the neck of the bladder.

The wound made in the operation may be said to represent a truncated cone, the apex of which corresponds with the neck of the bladder, and the base with the surface of the perineum. In the adult, its extent externally varies from three inches to three inches and a half, while internally it does not, as a general rule, exceed fifteen or eighteen lines. Its superior angle is an inch and a quarter above the verge of the anus, and immediately on the left side of the *raphé* of the perineum; the inferior, on the contrary, is usually about three-quarters of an inch to an inch below the anus, and a little nearer to the tuberosity of the ischium, than to the outlet in question. The inner wall of the wound corresponds with the middle line of the perineum; the external, with the ramus of the ischium and the erector muscle of the penis.

The evening before the operation, a brisk purgative is administered, to clear out the alimentary canal. The article which I usually select for this purpose is castor oil; but if the secretions are disordered, as indicated by the state of the tongue and stomach, a combination of calomel and rhubarb, with a few grains of jalap is to be preferred. If the rectum has not been thoroughly evacuated, a stimulating enema, consisting of tepid salt water, is thrown up a few hours before the operation. It is

of paramount importance, both as it respects the safety of the lower bowel, and the comfort of the surgeon, that this precept should be faithfully attended to. Moreover, by opening the bowels freely, immediately before the operation, there will generally be no necessity for any purgative medicine for some days after.

The urine should be retained for several hours before the operation, as a certain degree of distention of the bladder is necessary to prevent injury of its walls, and facilitate the extraction of the foreign body. If, as in the case of a child, the patient cannot hold his water without great difficulty, a piece of tape should be tied loosely around the penis, otherwise he will be sure to disobey an injunction which every lithotomist must regard as of no little consequence. In old subjects, affected with excessive irritability of the bladder, and with a constant desire to micturate, it is necessary to inject the organ with a few ounces of tepid water just before the operation.

During the operation the patient lies upon his back, on a narrow breakfast table, about four feet in length, with stout, firm legs, to prevent it from shaking. It is covered with a folded blanket, over which are spread, first, a piece of soft oil-cloth, and, next, a folded sheet. Several pillows are required for the head and shoulders, which, however, should be but slightly raised, otherwise the abdomen will be doubled up, and thus unduly compress the bladder. The breech is fully exposed to the operator, and is, therefore, brought well down over the edge of the table.

If an anæsthetic be used, there will be no necessity for tying the hands and feet; otherwise they should be secured by two stout worsted bands, from six to eight feet in length by two inches and a half in width, with a hole in the middle to afford greater security against their slipping; or they may be arranged as in fig. 549. As a preliminary step, the patient, stripped to his shirt, and placed upon the table, is desired to grasp his feet in such manner as to apply his fingers to the sole and the thumb to the instep; in which position they are confined by means of the fillets, passed around them in the form of the figure 8, the ends being tied in a double knot, or fastened with stout pins. This duty is generally confided to the assistants, for which reason it is often discharged so badly as to be followed by much delay and annoyance, the patient, perhaps, becoming untied during the operation. A careful supervision should, therefore, always be exercised in this respect by the surgeon.

The limbs, bound as here directed, are given in charge of two assistants, who, one standing on each side of the patient, place one hand upon the top of the knee, and the other beneath the sole of the foot. When the operation is about to be commenced, the thighs are moderately separated from each other, and held nearly at a right angle with the trunk. It can easily be perceived how important it must be, in reference to the speedy and successful execution of the operation, that the patient's limbs should be thoroughly controlled, and out of the surgeon's way. It is usually recommended that the staff should be introduced previously to the ligation of the patient; but to such a procedure I am altogether averse, because it is productive of serious annoyance to the patient, and is almost sure to be followed by a premature escape of the urine. Besides, it is a source of inconvenience to the persons who have charge of the limbs. My rule, therefore, always is to tie the patient first, and immediately after to introduce the staff; taking care to confide it to a good, intelligent assistant, one who is thoroughly acquainted with the anatomy of the pelvis, and the different steps of the operation. A poor staff-holder is a great nuisance; for he often excessively embarrasses the surgeon, and makes him commit blunders which he might otherwise avoid. During the operation, the instrument is to be held perpendicularly, with the handle nearly at a right angle with the trunk, and inclined slightly towards the right side. The curved portion, securely lodged in the bladder, is hooked up closely against the pubic symphysis. The object of this advice is to prevent the instrument from pressing upon the rectum, which would thus be in danger of being wounded. By inclining the handle of the staff a little towards the right groin, the curved portion is made to bear against the left side of the perineum, with the effect of rendering it somewhat prominent and thereby facilitating the division of the membranous

Fig. 549.

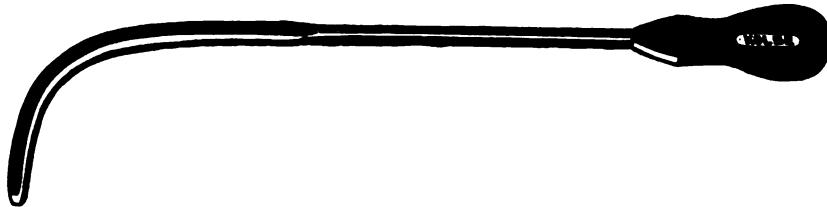


Lithotomy Bandage.

portion of the urethra. The assistant having charge of the instrument stands on the left side of the patient, in order that he may use his right hand, and also hold the scrotum out of the way.

The staff which I am in the habit of using is represented in fig. 550. It is shaped like an ordinary silver catheter, and is about ten inches in length, exclusive of the handle, which should be at least two inches long, by two lines and a half in thickness and fifteen lines in width, with a very rough surface, that it may be the more securely

Fig. 550.



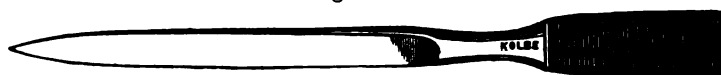
Grooved Staff.

held in the hand. The groove, placed a little towards the left side, and extending from near the middle of the instrument to within a short distance of its beak, should be perfectly smooth, and as deep and wide as possible. The instrument, warmed and oiled previously to its introduction, should be large enough to distend the urethra to as great a degree as may be compatible with the patient's comfort. By adopting this advice, it will be comparatively easy to find the staff, and to effect, in a safe and proper manner, the division of the neck of the bladder and the prostate gland.

The surgeon, during the operation, sits upon a low, firm chair, or stool, as he may find it most convenient; or he may place himself, as I usually do, in the half-kneeling posture, resting upon the right knee. I generally prefer this posture, because it affords greater freedom to my hands and elbows. A piece of old carpet, or a sheet, is laid upon the floor, under the patient's breech, to receive the fluids.

The knife which I have, for many years, been in the habit of using is the one sketched in fig. 551; it is of simple construction, very light and slender, sharp-

Fig. 551.



Lithotomy Knife.

pointed, and nearly seven inches in length, of which three are occupied by the blade, which hardly exceeds two lines in width. With this instrument, the lateral operation may be safely and expeditiously executed in all its stages. For enlarging the opening in the prostate and neck of the bladder, after the withdrawal of the staff, I sometimes use the probe-pointed bistoury, delineated in fig. 552, although the sharp-pointed

Fig. 552.



Beaked Knife.

is quite as safe, provided the extremity is carefully guided along the index-finger as it lies in the bottom of the wound.

Everything being thus prepared—the bowel cleared out, the instruments arranged on the tray, the limbs tied and held out of the way, the staff in the bladder and in the hand of the assistant, the breech projecting over the table, and the patient fully under the influence of chloroform—the operator is ready to begin. Introducing the index-finger, well oiled, into the rectum, to induce it to contract, and to enable him

to ascertain the position of the staff, and marking with his eye the situation of the tuberosity of the ischium, he stretches the integument of the perineum with the thumb and finger of the left hand, and commences his incisions. The knife is entered just at the edge of the raphé, on the left side of the perineum, an inch and a quarter above the margin of the anus, and is carried obliquely downwards and outwards, a short distance below the tuberosity of the ischium, and a little nearer to this point than to the anus, as shown in fig. 553. If the part is unusually full, the instrument is plunged in at the first stroke to the depth of at least one inch; otherwise it must be used more cautiously. As the knife descends, it is gradually withdrawn from its deep position, so as to give the wound a sloping appearance. The length of the incision must be regulated by the size of the perineum and the age of the patient; but, in the adult, it should not, in general, be less than two and a half to three inches. In the young subject, it must, of course, be proportionately smaller.

Placing the point of the left index-finger in the upper angle of the wound, the knife is reëntered just by the side of it, and is made to divide, by repeated touches with its edge, the deep cellular substance of the perineum, the transverse muscle, and a portion of the triangular ligament, with a few of the fibres of the elevator muscle of the anus. The membranous portion of the urethra being thus exposed, a little in front of the prostate gland, the surgeon feels for the groove of the staff, at the bottom of the wound, and cuts into it through the denuded tube, the finger-nail serving as a guide to the point of the knife, as in fig. 554. The length of the opening in the urethra need not exceed the third of an inch.

The knife, inserted into the groove of the staff, through the opening in the urethra, is now carried on into the bladder, dividing, as it proceeds, the neck of the organ and the left lobe of the prostate, in a direction obliquely downwards and outwards, which is in that of its long axis. In executing this step of the operation, the rectum is to be held out of the way, by pressing it over towards the right side with the left index-finger, which should be steadily kept in the bottom of the wound, from the moment of the first incision. Great care should also be taken not to prolong the incision in the prostate gland too far back, for fear of penetrating the reflection of the pelvic fascia and the adjacent venous plexus.

As soon as the bladder has been opened, the urine generally escapes in a gush; the knife is now removed, and the finger, lying in the bottom of the wound, is placed in contact with the staff, which is immediately withdrawn. The urine, as it passes off, commonly forces the calculus down against the artificial opening, so as to afford the surgeon an opportunity of ascertaining its form and bulk. When it fails to do so, the finger is carried into the bladder to its full length, and used as a searcher. If the stone is found to be disproportionately large, the wound must immediately be dilated, either with the finger or the bistoury, according as the resistance may seem to depend upon the prostate or the muscular structures. In elderly subjects, the instrument will generally be necessary, as the gland is not sufficiently lacerable to yield to pressure.

The incisions being completed, the next step of the operation is to extract the calculus. This is done with the forceps, fig. 555, conveyed into the bladder along the upper surface of the index-finger, as it lies in the bottom of the wound, in contact with the foreign body. The forceps are introduced with the blades closed, and are

Fig. 553.



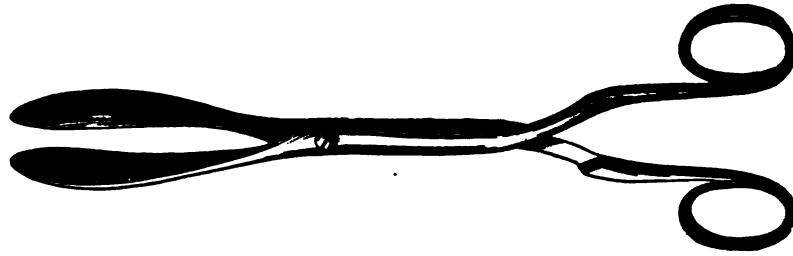
Lateral Operation for Stone.

Fig. 554.



The Finger and Knife in the Groove of the Staff

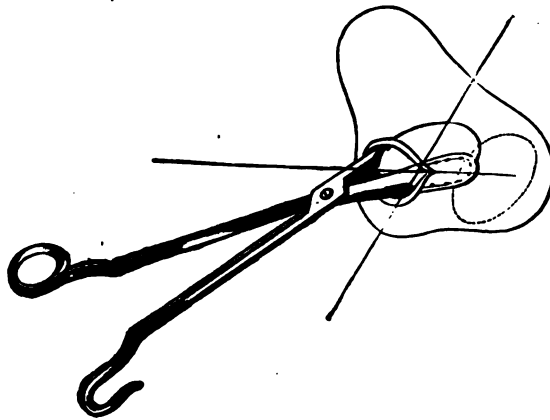
Fig. 555.



Lithotomy Forceps.

used at first as a searcher. As soon as they are brought in contact with the concretion, the blades are expanded over it, in the direction of its long axis, with a firm grasp, as seen in fig. 556, to prevent the risk of slipping. Taking

Fig. 556.



Mode of Introducing the Forceps and Seizing the Stone.

care that the instrument does not embrace any of the folds of the mucous membrane, the operator endeavors to extract the foreign substance by gently moving the forceps from side to side, or upwards and downwards, on the same principles as in the delivery of the child's head. The facility with which the stone may be seized depends upon circumstances. In general, it lies in contact with the inner extremity of the wound, and may readily be caught in the embrace of the blades of the instrument. Sometimes, however, as when it is lodged in the *bas-fond* of the

organ, it refuses to come down, and may thus embarrass the operator. The difficulty, as will be particularly mentioned hereafter, is easily remedied by inserting the finger into the rectum, and pushing the concretion forwards against the forceps. When the stone is situated in the superior fundus of the bladder, the forceps must be carried high up, in the direction of the long axis of the pelvis, where they are to be moved about as a searcher. Occasionally it lies behind the pubic symphysis, and cannot be seized until it has been dislodged by pressure upon the inferior part of the hypogastric region, aided by the finger in the bladder.

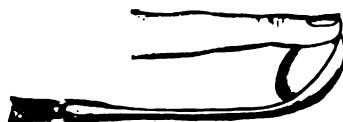
Fig. 557.



Lithotomy Scoop.

If the calculus is very small, it is sometimes more easily extracted with the scoop, fig. 557, than with the forceps. The same instrument should be used when the concretion has been broken, whether accidentally or designedly, into fragments,

Fig. 558.



Scoop and Finger Grasping the Calculus.

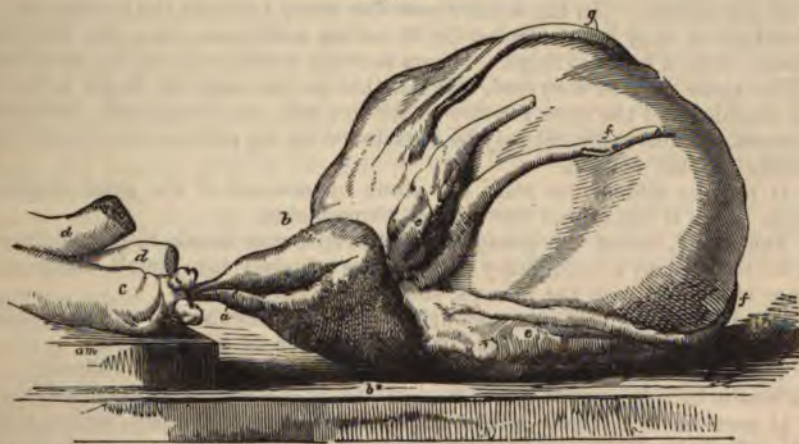
which must then be removed piecemeal. The scoop is about ten inches in length, and is shaped, as its name indicates, at each extremity, like a spoon. or, instead of this, one end is provided with a suitable handle. An instrument like this may be made very serviceable in extracting an adherent, encysted, or impacted concretion. The mode of grasping and holding the stone is exhibited in fig. 558.

As soon as the foreign body has been extracted, the bladder is washed out with tepid water, thrown up in a full stream from a large syringe. Any pieces or fragments that may have escaped the forceps or scoop are thus removed; otherwise, there will almost certainly be a return of the calculous affection, the smallest particle frequently serving as a nucleus for a new concretion. The bladder having been washed out, a female sound is next introduced through the wound into the interior of the viscus, with a view of ascertaining whether any stones or fragments have been left behind. Should this be the case, the forceps, scoop, and syringe are again used until complete clearance is effected. In general, when the stone is rough, it is an evidence that it is solitary; but to this rule there are occasional exceptions. The operation being finished, the patient is conveyed to his bed, a piece of oil-cloth and a folded sheet being placed under his breech, to protect the clothing and absorb the urine.

Although the left side of the perineum is usually selected in performing this operation, circumstances may render it necessary to cut on the right side. Thus, in a case which occurred in the practice of Professor Pope, of St. Louis, a vicious projection of the thigh, caused by ankylosis of the hip-joint, offered an effectual barrier to the left lateral section; and in an instance recorded by Zeiss, a similar course of procedure was necessitated by the occupation of the left side of the perineum by a congenitally displaced testicle.

Extent of the Incision of the Prostate.—The wound should in no instance, however bulky the stone may be, extend entirely through the lateral lobe of the prostate, on account of the danger of urinary infiltration. When the concretion is very voluminous, it should either be broken, and extracted piecemeal, or, what is better, the opening should be enlarged by incising the opposite half of the gland. If this do not afford sufficient room, the calculus should be crushed. In ordinary cases, I incise the organ only to a very limited extent, and immediately after enlarge the opening with the finger, the pressure of which is generally amply sufficient for the purpose. When it is not, a probe-pointed bistoury is used as a substitute. In old subjects, with induration and enlargement of the gland, the division is generally obliged to be effected with the instrument. The outer wound, on the other hand, should always be ample and dependent. The direction and extent of the incision in the prostate gland are represented in fig. 559, from Scarpa.

Fig. 559.



Left Lobe of the Prostate, as it is Divided in the Lateral Operation. *a*. Marks the Incision of the Membranous Portion of the Urethra and the Side of the Gland. *b*. The Left Lobe of the Prostate. *b**. The Right Lobe of the Organ. *c* The Bulb of the Urethra. Close behind are observed Cowper's Glands. *d, d*. The Crura of the Penis. *e, e*. The Seminal Vesicles. *f, f*. The Deferent Ducts. *g*. The Ureter of the Left Side.

In children from eighteen months to ten years, if, indeed, not until a considerably later period, the prostate is so small as to render the introduction of the finger and the forceps into the bladder, and, consequently, the extraction of the calculus, however diminutive, impracticable without the division of the gland in its entire length. I am quite sure that this has happened in all my operations, fifty-two in

number, and yet I have never met with a solitary instance in which the procedure was followed by infiltration of urine. The annexed drawings, figs. 560 and 561, copied from personal dissections, exhibit the size and shape of the prostate at four and twelve years.

Beyond the fact here mentioned, lithotomy in the child presents nothing peculiar. The operation is generally one of the most easy and simple in surgery. My practice

Fig. 560.



Fig. 561.



Prostate at Four Years. Prostate at Twelve Years.

now invariably is to make a small external incision, and, after opening the membranous portion of the urethra, to divide the prostate gland and neck of the bladder with the finger. This can always be done with the greatest facility, as these structures, at this period of life, are remarkably soft and lacerable. To prevent the knife from passing into the cellular substance between the bladder and the rectum, the index finger should be kept in close contact with the upper part of the

wound, just below the arch of the pubes, otherwise the instrument may wander away from the staff, and thus lead to the idea that the bladder has been penetrated, when, in reality, it has not been opened at all. The staff should not be withdrawn until the surgeon is well assured that the finger is fully in the organ, or, what is still better, in contact with the stone. Extraction is usually easily effected, either with the forceps or the scoop.

Difficulties of Extraction.—Difficulty frequently occurs in the extraction of the stone. This may depend, 1st, upon the stone itself; 2d, upon the bladder; and 3d, upon the pelvis.

1st. The impediment may be caused by the lodgment of the stone in the *bas-fond* of the bladder, which, especially in elderly subjects with enlarged prostate, is sometimes converted into a deep cul-de-sac. The remedy is to raise the stone up, and place it within reach of the instrument, with the left index-finger, inserted in the rectum. When the stone lies above the pubes, it is to be dislodged, while compression is made upon the hypogastrium, with a strong probe, bent into a hook, or it may be drawn down with the index-finger.

2d. The stone may be entangled in the folds of the mucous membrane; or spasmodically grasped by the bladder, which may thus prevent the expansion of the blades of the forceps. In the former case the scoop replaces the forceps, or, if this fail, dislodgment may be attempted by throwing cold water into the bladder, in a full stream, from a large syringe. Spasm is most readily relieved by anæsthetics.

3d. The stone may be encysted. When this is the case, the finger is introduced into the bladder and the cyst ruptured with the nail, or a long knife, fashioned like a gum lancet. Embarrassment may be occasioned by the presence of a pouch between the bladder and the rectum.

4th. It may be difficult to seize the stone on account of the great depth of the perineum, which is sometimes upwards of three inches.

5th. The stone, under the grasp of the forceps, may break into numerous fragments, be reduced to a soft, pulpy mass, or be crushed into small sandy particles. Clearance is effected with the forceps, scoop, or syringe.

6th. Delay and inconvenience may arise from the presence of a considerable number of calculi, necessitating the frequent introduction of the forceps.

7th. The manner in which the stone is grasped may occasion difficulty. When there is reason to believe that it has been seized by its transverse diameter, the finger should at once be introduced into the wound to ascertain the fact, and to effect the necessary change. Before this can be done, however, the forceps must relax their hold upon the calculus, although there will be no need of withdrawing them.

8th. Embarrassment occasionally results from an inability to find the concretion. This may depend upon some of the causes already detailed; or it may be owing to the expulsion of the stone, especially if it is of small volume, at the moment of completing the section of the bladder and the prostate gland.

9th. Great impediment sometimes arises from the size of the stone. When this is the case, the extraction is to be accomplished either by simply enlarging the wound, if this has not already been done, to the utmost permissible limits; by in-

cising the right lobe of the prostate to the same extent as the left; or, finally, by breaking the concretion, and removing it piecemeal.

With the view of facilitating the extraction of large concretions, Sir William Ferguson has recently proposed to combine a semilunar external incision with lateral section of the prostate, and Mr. Henry Lee practises a superficial incision, which, commencing in the raphé, extends through the posterior half of the perineum to two or three lines in front of the anus, from which it is carried outwards and backwards so as to embrace one-fourth of the circumference of the bowel, the operation being completed as in the ordinary lateral method. These so-called improvements are, in my judgment, steps in a retrograde direction, since the free external incisions retard recovery, while they do not afford a larger opening for the passage of the stone at the points where resistance is encountered, namely, the neck of the bladder and the prostate gland.

10th. Enlargement of the wound is effected with the probe-pointed bistoury, carried downwards and outwards in the direction of the original incision, while the stone is held firmly by the forceps. Or, the right lobe of the prostate is divided, if necessary, in the same manner and in the same direction as the left. These two methods may almost always be resorted to with a reasonable prospect of success, when the weight of the stone does not exceed three or four ounces. When the concretion is very bulky, crushing will generally be necessary; and for this purpose I know of no better instrument than the forceps represented in fig. 562. They are

Fig. 562.



Stone-crusher.

constructed upon the principle of an ice-masher, and do their work most effectually. The blades should be at least four inches in length.

11th. Embarrassment of a very serious, if not an insurmountable, character, may arise from unusual narrowness of the pelvis. Such a defect occasionally exists in children, but is most common in elderly men, and always necessitates additional care in the use of the forceps, especially when there is an unusually large calculus.

12th. The calculus occasionally coexists with calcareous incrustation of the surface of the bladder. The proper procedure is, first, to extract the stone in the usual manner, and then to remove the deposit with the forceps, scoop, and finger, aided with the syringe.

Lastly, calculi of large size, weighing ten, twelve, and even fifteen ounces, have occasionally been successfully extracted. Most generally, however, the patient dies either from exhaustion during the operation, or a short time after from the effects of inflammation.

Accidents.—The accidents that are most liable to occur, during and after the lateral operation, are hemorrhage, prostration, retention of urine, undue inflammation of the wound, cystitis, injury of the prostate gland, urinary infiltration, peritonitis, tetanus, lesion of the rectum, ischuria, incontinence of urine, impotence, perineal fistule, orchitis, and explosion of the preëxisting disease.

1. *Hemorrhage.*—The hemorrhage after perineal lithotomy is usually very slight, not exceeding two or three ounces. It may be arterial or venous, primary or secondary. Its principal sources are the artery of the bulb and the superficial artery of the perineum. In old subjects, a copious flow of blood occasionally proceeds from the veins of the neck of the bladder and of the prostate gland. The pudic artery, in its natural course, can hardly be wounded posteriorly; anteriorly, however, it is more exposed, and, therefore, in danger of being injured. The accident is most likely to happen when the prostate is divided with the gorget, or the lithotome caché. The artery of the bulb sometimes bleeds profusely; and from its deep position, and the readiness with which it retracts, is always secured with difficulty. A

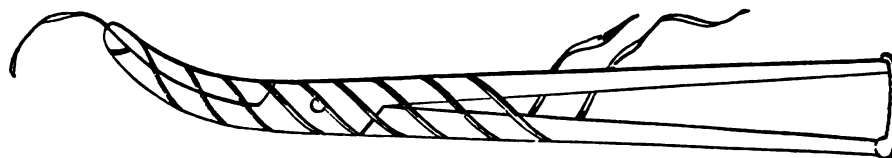
case in which death resulted from its division is recorded by Dr. Kerr, in the Edinburgh Medical and Surgical Journal for July, 1847.

A tremendous gush of blood sometimes proceeds from the transverse perineal artery. The bleeding generally follows the first incision, and should immediately be arrested with the ligature. The superficial perineal artery is seldom cut; when it is, the bleeding is usually insignificant.

When the affected vessel is deep-seated, the blood, instead of escaping externally, may pass into the bladder, where it is either retained, or expelled from time to time in thick clots. The organ, in the latter case, forms a hard, solid tumor, which is more or less tender on pressure, and which may mount as high up as the umbilicus. The expulsion of the clots is attended with violent spasm and tenesmus, bearing a close resemblance to labor pains.

When the bleeding vessel is accessible, the proper means for arresting the hemorrhage is, of course, the ligature. When it is very deep-seated, it may generally be readily seized with Physick's artery forceps, delineated in fig. 563, the edges of the

Fig. 563.



Physick's Forceps.

wound being separated with retractors, the fingers, or a pair of lithotomy forceps. When the artery is situated very far back, at the neck of the bladder, or by the side of the prostate gland, it may be extremely difficult, if not impossible, to ligate it.

Fig. 564.



Arterial Compressor.

Fig. 565.



Canula for Plugging the Wound in Lithotomy.

To meet this contingency, I devised, many years ago, a pair of forceps, which, after having grasped the artery, may be permanently retained, by unscrewing its handle, until all danger from hemorrhage is over. The instrument is represented in fig. 564.

Compression may be resorted to, when it is impossible to use the ligature, acupressure, or torsion. A canula, fig. 565, consisting of silver, gutta-percha, or gum-elastic, three inches and a half long by four lines in diameter, open at the vesical extremity, provided with two large

eyelets, and surrounded with a chemise, is inserted into the bladder, previously emptied of clots, when the chemise is tightly plugged with charpie, tow, or cotton. The instrument is then secured by means of pieces of tape to a double T-bandage, and answers the twofold purpose of conducting off the urine, and compressing the bleeding vessels. It should be retained for several days, or until there is reason to believe that all danger of hemorrhage is over. When no canula is at hand, a female catheter, a piece of reed, or the spout of a tin coffee pot, may be used as a substitute. Plugging of the wound is particularly necessary when the hemorrhage proceeds from enlarged and varicose veins at the neck of the bladder and prostate gland, or when the blood oozes from a great many small arteries, too minute to be tied. The operation, of course, always interferes with the union of the wound.

Compression may sometimes be advantageously employed by the finger in the rectum, as in an instance related by Marjolin. The patient, a child, bled obstinately after the operation, but the flow was effectually stopped by maintaining the compression in this manner for three-quarters of an hour. Applying the finger directly to the bleeding vessel generally answers a much better purpose, and may readily be maintained for many successive hours by a relay of assistants.

Styptics are sometimes useful, especially in deep-seated venous hemorrhage, the

best articles for the purpose being alum, acetate of lead, and subsulphate of iron, especially the latter, which, in fact, is the only reliable one. In cutting, not long ago, a man, sixty-four years of age, with great enlargement of the prostate gland, the blood oozed from numerous points more freely than I had ever witnessed before, but was instantaneously checked upon the introduction into the wound of a soft sponge wet with a saturated solution of Monsel's salt. The plug was removed three days afterwards, without any recurrence of the bleeding, or material interference with the healing process. The actual cautery can seldom be required.

Occasionally the hemorrhage is promptly arrested by directing a concentrated stream of cold water from a syringe upon the bleeding spot. Exposure of the wound to the cold air, and keeping it free from clots, is also sometimes highly beneficial.

Secondary hemorrhage generally takes place as soon as reaction is established, or the patient has recovered from the shock of the operation. The means already pointed out will usually be sufficient to arrest it.

2. *Sinking*.—Few patients, at the present day, suffer seriously from shock in this operation. Should such an event arise, as it may when there is great debility, or rough and prolonged manipulation, especially in very young children and elderly subjects, recourse must be had to stimulants, care being taken during reaction that over-excitement does not occur.

3. *Retention of Urine*.—This may be caused by inordinate tumefaction of the wound, and spasm of the urethra; or, as more frequently happens, by closure of these passages by coagulated blood. In the former case, relief is afforded by the catheter; in the latter, by clearing away the blood, and preventing further hemorrhage.

4. *Inflammation of the Wound*.—It is seldom that the wound becomes unduly inflamed after such an operation. The occurrence will be most likely to supervene within the first forty-eight hours. The action is sometimes erysipelatous, and is then apt to spread. The treatment should be strictly antiphlogistic, combined with gently supporting measures, if there is any tendency to prostration.

5. *Phlebitis*.—This disease occasionally occurs after this operation. It is most frequently met with in elderly subjects. The treatment, although antiphlogistic, is conducted cautiously, and with due regard to the state of the system.

When the phlebitis attacks the extremities, the proper local remedies will be leeches, fomentations, iodine, and blisters, followed by free incisions to afford vent to effused and pent-up fluids. The system must be supported by anodynes and stimulants. Venesection is generally inadmissible; and mercury, except in so far as it may tend to correct the secretions, is of no use. After the violence of the inflammation has subsided, the limb should be bandaged; and, as soon as the patient can move about, change of air should be advised.

6. *Cystitis*.—Slight cystitis is by no means uncommon after this operation, setting in within the first few days, and manifesting itself by a frequent desire to urinate, with more or less spasm, a sense of weight, and bearing-down pains. The most suitable remedies are hot applications to the perineum and hypogastrium, diluent drinks, and liberal doses of morphia. When the inflammation is urgent, local and general bleeding may be required.

In some cases, the inflammation, instead of attacking the bladder, invades the connective tissue between this organ and the rectum, and soon terminates in extensive suppuration, or the formation of abscesses. This occurrence is usually associated with serious renal disease, and generally ends fatally in from three to four weeks after the operation.

7. *Lesion of the Prostate Gland*.—This gland may be gravely injured in this operation, either by the forceps, or by the calculus. The most common occurrences are laceration and contusion, which may be so great as to be followed by severe inflammation, if not by gangrene. When the stone is very large, rough, or angular, such accidents are not always avoidable, although they are certainly infrequent in the hands of skilful lithotomists. The treatment must be conducted upon general antiphlogistic principles.

8. *Urinary Infiltration*.—One of the most dangerous effects of lithotomy, but, fortunately, one of the most infrequent, is an escape of urine into the cellular tissue of the perineum, or of the perineum and the parts immediately around the neck of the bladder. Its occurrence is favored by too extensive a division of the prostate gland; by the small size of the wound, or by its being too conical and sloping; by the early and inordinate tumefaction of the cut surfaces; and, above all, by the perforation

of the reflected portion of the pelvic fascia. The attack usually comes on within a short time after the operation, and often runs its course with frightful rapidity.

Little can be done to arrest the progress of this affection when once established. Depletion by the lancet and by purgatives is wholly inadmissible. The system is to be sustained by such remedies as carbonate of ammonia, quinine, iron, camphor, and capsicum, in combination with the liberal use of brandy and opium. The best topical means are saturnine and anodyne fomentations, medicated cataplasms, injections of a weak solution of nitric acid or chlorinated soda, and touching the whole track of the wound as early as possible with nitrate of silver, or tincture of iodine. When the infiltration is caused by the small size, ill shape, or improper direction of the wound, the defect must be remedied by the knife, to afford a free outlet for the urine. Leeches and hot fomentations may be applied to the hypogastric region.

9. *Peritonitis*.—Peritonitis seldom follows the lateral operation, but is occasionally observed as a consequence of the high. Sir Henry Thompson asserts that this occurrence is much more frequent in children than in adults, and that, in them, it constitutes one of the chief sources of danger. As for myself, I have not noticed anything of the kind; indeed, I have met with peritonitis only in a single instance, after the lateral operation, in 115 cases. Much of the danger of peritonitis will, it may be presumed, depend upon the manner in which the operation is performed.

The treatment must be prompt and vigorous. Blood should be taken by the lancet, or, if this be inadmissible, by leeches from the hypogastrium, succeeded by anodyne fomentations. The bowels are thoroughly confined with opium, and the pulse is kept down with aconite and other depressants.

10. *Pyemia*.—Pyemia is probably of more frequent occurrence after this operation than is generally supposed. In 186 cases of lithotomy, analyzed by Mr. Smith, of Leeds, 4 perished from this cause. I have myself met with pyemia only once in all of my cases. The patient was a boy, three years old, who, although everything went on most favorably for the first week, died on the twenty-eighth day from numerous little abscesses in the left kidney. The wound itself was nearly healed.

Pyemia, as an effect of lithotomy, is most liable to occur in broken-down persons, especially if the stone is of great size, or the operation is unusually protracted, painful, or bloody. The disease, generally announced by violent rigors, followed by copious sweats and rapid prostration, may set in within the first twenty-four hours, although seldom so early, and usually ends fatally in less than a week. The structures which are most liable to suffer from abscesses are the kidneys, lungs, liver, joints, and cellular tissue. The treatment, which is seldom of any avail, is supporting, milk punch, quinine, and anodynes being the chief means.

11. *Tetanus*.—This occurs very rarely. Should an attack be threatened, the proper remedies are anodynes and antispasmodics, aided, if there is unusual debility, by quinine and alcoholic stimulants. Chloroform is a valuable adjuvant, when there is much suffering, in controlling muscular action.

12. *Wound of the Rectum*.—Such an accident may happen in the hands of the most skilful surgeon, but will not be likely to do so if the proper precautions are taken in performing the operation. The opening, which is generally situated immediately in front of the neck of the bladder, soon begins to diminish, and usually closes in a few weeks.

Some surgeons seem to regard this accident as of little moment. Several years ago a gentleman, who then stood high in the profession, said, in my presence, in conversing upon the subject, that he had opened the bowel not less than three or four times in twenty operations, without any serious consequences. An eminent English lithotomist, in 1865, publicly stated that the accident had happened to him repeatedly, and that he considered it of no particular importance as it respects the final result of the case. Cheselden wounded the rectum twice, and Deschamps four times. The accident also occasionally occurred to Frère Côme.

Now, although a wound of the rectum does not endanger life, or, perhaps, even materially interfere with recovery from the immediate effects of the operation, yet such an occurrence is not only "a blot in the operation which should be avoided," but it may render the patient miserable for life by entailing upon him a permanently incurable recto-vesical fistule, as I have had occasion to witness in not less than five cases in the hands of other surgeons.

The treatment consists in preventing the bowels from acting, except every third

or fourth day, by means of anodynes, in washing out the rectum frequently with cold water, in permitting none but the most bland and simple food, in enjoining strict recumbency, in the constant retention of the catheter, and in touching the edges of the wound every third or fourth day very gently with solid nitrate of silver, or a weak solution of acid nitrate of mercury. Chronic cases should be managed upon the same principles as harelip, that is, the edges of the fistule should be refreshed with the knife, and carefully united with wire sutures. When access to the bowel is rendered difficult, the best plan is to divide the sphincter muscles of the anus, immediately in front of the coccyx. Sometimes a cure may be effected by means of the actual cautery. When the fissure is situated at the neck of the bladder, or at the junction of the bladder and urethra, it may be necessary to lay these parts and the bowel freely open with the knife, as in the common operation for anal fistule.

13. *Sloughing of the Rectum*.—This is most likely to take place in weakly, dilapidated subjects. The immediate cause of the occurrence is probably slight infiltration of urine, in consequence of the great and unnecessary depth of the wound, or injury done to the recto-vesical septum during the extraction of the calculus. No definite rules can be laid down respecting the treatment, which must be regulated by the circumstances of each individual case. In general, it will be necessary to support the strength by proper diet and by tonics, especially quinine, wine, and brandy.

14. *Ischuria*.—Suppression of urine cannot be said to be peculiar to the lateral method, for it has occasionally been witnessed after the supra-pubic, and even after the recto-vesical operation. The affection, which is extremely uncommon, generally comes on suddenly within the first forty-eight hours after the patient is placed in bed, and is nearly always promptly fatal, from uremic poisoning. The most prominent symptoms are, excessive prostration, gastric irritability, intense thirst, copious sweats, and great stupor, with more or less delirium. The treatment principally consists in the exhibition of diuretics with quinine and strychnia, and the application of sinapisms, veratria ointment, and stimulating liniments to the dorsolumbar region.

15. *Incontinence of Urine*.—Incontinence of urine, consequent upon perineal lithotomy, is happily infrequent. It is not always easy to determine how this accident is produced. Most commonly, however, it arises from injury inflicted upon the neck of the bladder during the extraction of a large and very rough calculus, although I have known it to occur when the stone was unusually small.

When there is a probability that incontinence of urine will take place, every effort should be made to prevent it. The patient should be strictly confined to his bed, a warm bath should be administered once a day, for twenty-five or thirty minutes at a time, cold water should frequently be thrown into the rectum, and free use should be made of diluent drinks.

When the affection is fully established, it will be necessary to leech the perineum occasionally, and to apply gentle but steady pressure upon it with the pad of a T-truss. In obstinate cases, cauterization of the neck of the bladder and of the commencement of the urethra may be tried.

16. *Impotence and Sterility*.—These occurrences, which are very uncommon after perineal lithotomy, doubtless depend upon injury inflicted upon the ejaculatory ducts by the knife in making the deep incisions, and are, of course, irremediable. The two effects are not always associated. Thus, for example, a man may be able to copulate but not procreate, while another may be both impotent and sterile, as in a singular case communicated to me by Professor McGuire, of Richmond, Virginia, of a man, thirty-one years of age, who has had no erections, seminal emissions, or sexual desire since he was cut for stone, nearly two years ago, notwithstanding he is very strong and healthy, and perfectly free from vesical trouble. When only one ejaculatory duct is obliterated, the other remaining sound, the faculty of procreation would probably be little, if at all, impaired.

17. *Perineal Fistule*.—The wound made in lithotomy generally heals in from three to four weeks; but sometimes it remains open much longer, and occasionally it does not close at all, but degenerates into a fistule, the existence of which is determined by the appearance of the urine at the external opening, and by an examination with the probe.

The treatment consists in retaining a silver catheter constantly in the urethra,

and in cauterizing, every fourth or fifth day, the neck of the bladder with nitrate of silver. The patient should be confined to his back, with the nates elevated. When the track is unusually small, or the perineum uncommonly thin, relief may sometimes be afforded by the occasional introduction of a heated probe, wire, or knitting needle. In intractable cases, it may be necessary to incise the parts, and pare the edges of the wound.

18. *Orchitis*.—Acute swelling of the testicle occasionally follows this operation. I have seen only two cases of it in my own practice; a circumstance which leads me to suppose that it is infrequent. It seldom comes on before the end of the second or third week, and is no doubt due to injury inflicted upon the ejaculatory ducts in the division of the prostate gland or during the extraction of the calculus. It generally involves only one organ. The treatment is the same as in ordinary orchitis, the disease usually yielding in a few days.

19. *Explosion of Preëxisting Disease*.—Stone, as is well known, frequently coexists with other diseases, which, whether latent or open, often acquire new intensity on the removal of the vesical irritation. The organs most likely to suffer in this manner are the kidneys, bowels, brain, heart, and lungs. In old subjects death occasionally occurs, during the progress of the cure, from apoplexy. A patient of mine, a man, seventy-one years of age, perished from an attack of this kind six weeks after the operation, from the immediate effects of which he had thoroughly recovered at the time of his seizure.

After-treatment.—As soon as the stone has been extracted, the bladder washed out, and the bleeding arrested, the patient is carried to his bed, always properly arranged beforehand. It should be provided with slats, and a cotton, moss, or hair mattress, covered with a sheet, over which is spread a large piece of soft oil-cloth. Another sheet, called the draw-sheet, folded several times, and arranged so as to make the middle of it correspond with the buttocks, is placed upon the top of the oil-cloth, and serves to ward off pressure, as well as to receive the secretions as they flow from the wound. The head and shoulders should be slightly elevated by a pillow.

My experience is that it matters little, if any, what posture the patient assumes after he has been put to bed. I usually, however, request him to lie on his right side for the first five or six hours, to afford the lips of the wound an opportunity of becoming glazed with lymph before he is obliged to urinate. At the end of this period, and, indeed, often much earlier, I permit him to rest upon his back, or upon either side, as may be most agreeable. Young subjects, unless they are incessantly watched, seldom remain in the same posture beyond a few minutes, and I have never seen a case in which any detriment resulted from this source.

It is equally unnecessary, in my judgment, to tie the patient's knees together after the operation; or to introduce a tube into the bladder by the wound, to conduct off the urine, with a view, as is alleged, of preventing infiltration of the surrounding cellular tissue. The expedient can never be required except in those cases in which the incisions are unusually extensive.

The urine sometimes begins to flow by the wound in a few minutes after the operation; but, in general, very little, if any, passes for the first three or four hours. It then usually comes away in a gush, attended with pain and spasm of the neck of the bladder. By the end of the first day, the edges of the wound are commonly so much swollen as to compel the urine to pass mainly by the urethra. This, however, rarely continues beyond twenty-four or thirty-six hours, when the tumefaction has generally so far subsided as to allow the fluid to resume its original course. The period at which it begins to pass off permanently by the urethra varies from ten to fourteen days. The change in the direction of the fluid is always attended with more or less pain at the neck of the bladder, and a scalding, smarting, or burning sensation in the urethra and head of the penis.

The treatment after the operation must be strictly antiphlogistic. The patient is kept quietly in the recumbent posture, and all excitement, both bodily and mental, is sedulously guarded against. The pain consequent upon the operation is often extremely severe. It generally makes its appearance as soon as the patient wakes from the effects of the chloroform, and should be promptly met by a full dose of morphia, introduced, if possible, hypodermically.

Demulcent drinks should be used freely throughout the treatment, especially in the earlier stages. They serve both to allay thirst and to dilute the urine. They

may be simple, or combined with nitrate of potassa, bicarbonate of soda, or dilute nitric acid, according to the particular indications of the case.

The diet must be light, unirritant, and of the most simple kind. For the first few days the patient should take little else than panada, gruel, animal broth, or milk and bread. After that he may use rice, toast and tea, crackers, or mush and milk. No meat or vegetables should be permitted under five or six days, unless there is marked evidence of debility.

My invariable rule after this operation is to lock up the bowels for the first three days with a full anodyne, administered as soon as the patient has sufficiently recovered from the effects of the anæsthetic. At the end of this time a dose of castor oil or Rochelle salt is ordered, assisted, if necessary, by an enema.

Every possible attention should be paid to the cleanliness and comfort of the patient. Excoriation should be guarded against and the scrotum kept out of the way of the wound by a suspensory bandage. The smarting, burning or scalding sensation of the skin from the contact of acrid urine is always promptly relieved by covering the affected surface several times a day with benzoated zinc ointment. The free use of nitrate and acetate of potassa will tend to render the fluid less irritating.

When, as occasionally happens, the edges of the wound become covered with earthy phosphates, the best remedy will be the nitric acid lotion, in the proportion of about four drops of acid to the ounce of water, applied by means of a folded cloth. When the incrustation extends far back, the fluid may be daily injected into the bladder. In most cases the local application should be aided by the internal exhibition of the remedy. When the wound is tardy in healing, or has contracted to a mere orifice, indisposed to close, a catheter ought to be permanently retained in the bladder, to conduct off the urine through the natural channel.

Although the wound made in this operation occasionally unites by the first intention, such an event is extremely uncommon. I do not recollect a solitary example among my own cases, in which the parts were seriously bruised in the extraction of the calculus, or unduly divided in making the deep incisions, and yet I have never had an instance of union by the first intention, properly so called.

Statistics.—Of 1929 cases of the lateral operation of lithotomy with the knife in the hands of Cheselden, Martineau, Kern, Mott, B. B. Cooper, Brett, Pollak, Zett, Raddock, Teale, Vericel, Fergusson, Solly, Norgate, and myself, 1742 recovered and 187 died, or about 1 in 10½. My own practice, embracing 115 cases, shows 10 deaths, or 1 in 11½. Of 52 children all, except one, recovered, while of 63 operations in adults and old persons 9, or 1 in every 7, died.

Pouteau operated with the single lithotome upon 120 cases with a loss only of 3; Crichton saved 186 out of 200, cut partly with the knife and partly with the gorget; and Dudley, who operated exclusively with the gorget, had 207 cases with a loss of 6. Wattmann, of Vienna, who always employed a large knife, shaped somewhat like a gorget, lithotomized 180 cases, of which 146 recovered, and 34 died. Of 426 cases of the operation with the gorget in the practice, chiefly private, of American surgeons, the mortality was 1 in 23½.

The results of lateral lithotomy in hospital practice are not so encouraging as those in private. Thus, of 4155 cases, 3593 recovered, and 562 perished, the ratio of deaths being 1 in 7½. The mortality is greatly influenced by the weight of the calculus and the age of the patient. Thus, of 704 cases, analyzed by Mr. Crosse, the death-rate was nearly 9 per cent. when the stone weighed an ounce and under, while it was 26 per cent. when the weight was above an ounce. The experience of twenty surgeons in the Punjab and North-west Provinces of India, collected by Dr. Greenhow, furnishes 1718 cases of lithotomy, the majority of which were by the lateral method, of which 259 proved fatal, or 1 in 6.63. When, however, the weight of the stone was under one ounce, there was only 1 death in every 17, the mortality increasing in proportion to the weight. The influence of age upon the result is well shown by 1827 cases, of which 229 died, derived from hospital practice, and tabulated by Sir Henry Thompson. The mortality from 1 to 11 years was 5.7 per cent., from 12 to 16, 10.6 per cent., from 17 to 29, 13.5 per cent., from 30 to 48, 13.7 per cent., from 49 to 70, 24.2 per cent., and from 71 to 81, 31.5 per cent.

The circumstances which tend to influence the result of the lateral—as, indeed, of every other—operation of lithotomy are exceedingly numerous and diversified in their character, and are worthy of profound consideration. The most important of these circumstances are referable, 1st, to the skill of the surgeon; 2dly, the prepa-

ration, age, and health of the patient; 3dly, the nature, volume, and situation of the concretion; and, 4thly, the selection of our cases.

Nearly one-half of the patients that I have cut were under twelve years of age, and of these all, except one, promptly recovered. The youngest was a child of twenty months. My two oldest subjects were, respectively, seventy-three and seventy-seven. Both recovered. The late Dr. Gilbert, of this city, performed the lateral operation six times, all his patients being over fifty years of age. The three oldest were, respectively, seventy-four, seventy-eight, and eighty-one, and they all recovered without any untoward symptom.

The condition of the patient's health must necessarily influence the result of the operation. The more perfect this is at the time he is cut, the more likely, other things being equal, will he be to recover, and conversely.

The operation, as already pointed out, seldom terminates favorably when the stone is unusually large, as when it weighs five, six, or eight ounces, owing to the injury that must necessarily be inflicted upon the bladder, prostate gland, and other structures, often followed by infiltration of urine, erysipelas, phlebitis, and pyemia.

A patient worn out by physical suffering, or intercurrent disease, as diarrhoea, chronic dysentery, measles, or scarlatina, is a bad subject for an operation, and will be likely to perish from its effects.

Examples of the extraction of large calculi followed by recovery have been recorded by different authors. Thus, Dickinson had one of eleven ounces, Cheselden of twelve, Klein of thirteen, Mayo of fourteen, and Hamer of fifteen. In a case communicated to me by Dr. A. Dunlap, of Springfield, Ohio, he successfully extracted a stone weighing twenty ounces from a man sixty-six years of age, not, however, without breaking it into numerous fragments, as was easily done, as it was composed mainly of phosphatic matter. The patient survived the operation nearly three years. I have in my possession a plaster cast of a calculus weighing nearly five ounces and a half, kindly sent me by Dr. J. F. Thebaud, of New York, which he removed successfully by the lateral section from a man fifty-six years of age. Its different diameters measured, respectively, one and a half, two and a half, and three inches.

Relapse.—When it is considered that most vesical concretions have their origin in the kidneys, or, at all events, that these organs are often contemporaneously affected, it is not surprising that the disease should occasionally return after operation. What number of cases relapse after being lithotomized, is a point for the determination of which there are no positive data. There is no doubt that it is generally influenced by the nature of the calculous diathesis, and I think it is safe to affirm that persons affected with phosphatic calculi are more prone to suffer a second, and even a third time, than those affected with lithic concretions, or concretions composed of urate of ammonia. Diseases of the urinary organs, or of the digestive apparatus, may be mentioned as predisposing causes of relapse. Indeed, whatever has a tendency to disorder the general health, will be likely to promote the recurrence of the malady. Injuries of the spine, unless promptly relieved, are almost sure to be succeeded by relapse.

The period at which relapse occurs must, of course, depend upon circumstances. Occasionally, it is very short; and, on the other hand, a number of months, and even years, may intervene. As a general rule, the phosphatic and ammoniaco-magnesian calculi are more rapidly reproduced than the lithic and oxalic.

When the operation requires to be repeated it should be performed upon the same principles as in the first instance, and at the same place. I have myself never been obliged to cut the same patient twice, and in but one instance, so far as I recollect, has there been a return of the disease in any of my cases. Professor Hughes, of Iowa, has reported an instance in which he lithotomized the same individual, a man aged sixty-two, successfully four times in five years. Clever de Maldigny, a surgeon, was cut successfully six times, and Grangeret seven times.

Varieties in the Lateral Operation.—The operation described in the preceding pages is, as has been seen, executed with the knife, and nothing could possibly be more simple. It is the very perfection of lithotomy. Nevertheless, there are some surgeons who prefer the use of the gorget, the lithotome caché, or the beaked knife.

The operation with the gorget does not differ, in its early stages, from that with the knife. The period for using the instrument is immediately after the incision of the membranous portion of the urethra. The surgeon then exchanges the scalpel for the gorget, the beak of which is placed in the groove of the staff, guided by the point

of the left index-finger. After assuring himself, by drawing the instrument slightly backwards and forwards, that it is in no danger of slipping, he takes hold of the handle of the staff, and by a simultaneous movement of his hands, he lowers the instrument and the gorget nearly to a level with the abdomen; pushing at the same time the latter onward into the bladder. In executing this part of the operation, care should be taken not only that the gorget does not slip out of its place, and thus pass between the rectum and the bladder, but that it is properly lateralized, otherwise there will be great risk of injury to the rectum and the pudic artery. The annexed engraving, fig. 566, exhibits the gorget as modified and improved by Physick and Gibson.

Fig. 566.



Physick's Gorget.

Instead of the gorget, some lithotomists employ a *beaked knife*, or a probe-pointed bistoury, for dividing the neck of the bladder and the prostate gland. The instrument may be either straight, or somewhat concave on its cutting edge. The one which I generally use, if I use any of the kind at all, is represented at p. 786.

The *single lithotome*, invented, I believe, by Frère Côme, is now seldom employed. The annexed cut, fig. 567, represents the instrument, as modified and improved by

Fig. 567.



Single Lithotome.

Charrière. It will be observed that it has a single blade, moved by a spring, and concealed in a rod, fixed in a stout handle, and surmounted by a beak, to enable it to slide the more easily and securely in the groove of the staff. The extent to which the blade may be opened is regulated by means of a screw attached to the spring.

The external incisions having been made in the ordinary manner, and the membranous portion of the urethra being fully exposed, the beak of the lithotome is inserted into the groove of the staff, and passed on into the bladder. The blade is then expanded to the requisite degree, and the division of the deep structures effected in withdrawing the instrument, its edge being directed obliquely downwards and outwards, in the long axis of the prostate gland.

Bilateral Operation.—The merit of devising this operation is usually ascribed to Celsus, although it more probably belongs to Le Dran. Its advantages have been prominently set forth in modern times by Chaussier, Bécclard, and Dupuytren, the latter of whom, having first performed it in 1824, may be said to have regularized and perfected it.

If the bilateral section possesses any advantages over the ordinary method, it must be on the ground of its affording a larger opening for the passage of the foreign

Fig. 568.



Double Lithotome.

body, and that it is attended with less danger to the rectum and the seminal ducts. But even of these the former is, in great degree, counterbalanced by the modern method of dividing the right lobe of the prostate, if the wound in the left be found

insufficient for the extraction of the calculus. The operation has sometimes been performed instead of the lateral, on account of difficulty occasioned by malposition of the thigh. It requires the same preliminary measures as the other method. The incisions through the perineum, as far as the groove of the staff, are executed with an ordinary scalpel, and the prostate is divided with a double lithotome caché, seen in fig. 568, a narrow knife, or a probe-pointed bistoury, according to the fancy of the surgeon.

The operation consists in making a semilunar incision across the perineum, beginning on the right side, midway between the tuberosity of the ischium and the margin of the anus, but a little nearer the former than the latter, and terminating at the corresponding point of the opposite side, as seen in fig. 569. The concavity of the

Fig. 569.



Bilateral Operation.

cut is directed downwards, and its centre, situated at the raphe of the perineum, is about nine lines above the anus. In this direction are successively divided the skin, cellulo-adipose tissue, and superficial fascia, together with a few of the anterior fibres of the external sphincter muscle. The end of the left fore-finger is now placed in the bottom of the wound, as in the ordinary procedure, the staff sought, and the membranous portion of the urethra laid open, by an incision not exceeding four lines. The nail of the finger is then applied to the staff, to serve as a guide to the lithotome, the beak of which is next inserted into the groove of the instrument, with its concavity upwards.

Taking care, by moving the lithotome several times forwards and backwards, that it is securely lodged in the groove, the surgeon seizes the handle of the staff, and depresses it nearly to a level with the abdomen, at the same time that he lowers the lithotome, and pushes it onward into the bladder. As soon as the instrument has reached the viscus it is turned round with its concavity towards the rectum, and while it is in this position it is withdrawn, its blades being expanded by pressing their springs. In this manner it cuts its way out, slowly and steadily, dividing in its retrograde course the sides of the prostate, in a direction obliquely downwards and outwards, as in the ordinary section. The finger now takes the place of the instrument, the situation of the stone is ascertained, the forceps are introduced, and extraction is effected in the usual manner.

Various modifications of the bilateral operation have been proposed, but it is questionable whether they possess any advantages over the original procedure. The first, practised by Civiale from 1829 to the date of his death, consists in opening the membranous urethra as in the ordinary median operation, and incising both lobes of the prostate in a transverse direction with a straight double lithotome, the width of the superficial and deep incisions being less than in Dupuytren's procedure. The second modification is the prerectal operation devised by Nélaton and also adopted by Richet. The crescentic incisions are carried close to the rectum, with the view of avoiding the bulb of the urethra; the rectum being depressed, the operation is finished with the double lithotome. The procedure possesses no merit, and subjects the patient to longer confinement and the liability to the occurrence of urinary fistule.

No statistics have yet been furnished, on an enlarged and reliable scale, of the results of this operation. In the posthumous work of Dupuytren, who introduced this method into France, and who imparted to it much of its present perfection, is a table comprising 89 cases, of which 19 terminated fatally, making an average mortality of 1 in $4\frac{1}{2}$. It is proper to add that four of these cases occurred in females, who all recovered.

Of 139 cases of this operation by American surgeons, as Mussey, Spencer, Stevens, Parker, Eve, Hughes, and others, 125 recovered and 14 died, showing a mortality in the proportion of about 1 to 10. Of these Eve has had 87 cases, with 8 deaths, and Hughes 21, of which 1 was fatal. If to these cases be added those of Dupuytren, there will be an aggregate of 228 cases, with 33 deaths, or a loss of 1 in $6\frac{9}{10}$. Dr. Mott, in 1834, extracted by this method a calculus weighing upwards of seventeen ounces. The patient, a man twenty-one years of age, survived the operation five days.

Median Operation.—Attention has recently been directed to this operation by Professor Rizzoli, of Italy, who, at the date of his publication, had performed it eight times, and in every instance successfully. As the name indicates, it consists in opening the bladder at the raphé of the perineum, which, as a preliminary step, is rendered as prominent as possible by means of a curved staff.

It is not difficult to conceive that this operation might answer admirably in cases of small calculi, while it might be very objectionable in large ones, on account of the inadequacy of the wound, which is comparatively diminutive. It certainly possesses the advantages of freedom from hemorrhage and from injury to the rectum and seminal vesicles.

Medio-Lateral Process.—Professor Buchanan, of Glasgow, proposed, some years ago, to enter the bladder along the middle line by means of a rectangular staff, with the groove on the left side, and a straight, narrow knife, with a long edge, shaped at the point like a scalpel, but fitted to stab as well as to cut. The staff, introduced into the bladder, is moved backwards and forwards, over the left index-finger in the rectum, until the prominent angle is distinctly perceived in the perineum, at the anterior verge of the anus, or at the portion of the raphé where the skin and mucous membrane are insensibly blended with each other. The instrument is now confided to an assistant, with a request to maintain it firmly in its position, with the handle inclined towards the abdomen. The surgeon, holding the knife horizontally with the edge towards the left side, as in fig. 570, penetrates the skin and other tissues of the perineum until the point is partly in the groove of the staff, when he conducts it directly onwards until it reaches the bladder, a circumstance which is always indicated by the escape of a few drops of urine. Withdrawing the knife from this position, he now carries it obliquely downwards and outwards, for three-quarters of an inch, in the direction of the forepart of the tuberosity of the ischium, and then finishes by cutting, for three-eighths of an inch, almost vertically downwards. If the wound is not sufficiently spacious to admit of the easy extraction of the calculus, it may afterwards be enlarged to any desired extent.

The advantages which Dr. Buchanan claims for this procedure are, 1st, that it is more easily and rapidly executed than the ordinary lateral one; 2dly, that it is less severe, because of the less extensive division of the parts; and, 3dly, that it is not attended with so much risk of hemorrhage, of injury to the rectum, and of urinary infiltration. Of 52 operations for stone, performed according to this method, by Dr. Buchanan and Dr. Lawrie, in the Glasgow Infirmary, 47 recovered, and 5 died, thus showing a mortality in the proportion of 1 to 10.4.

Lithectomy.—Perineal lithotomy is occasionally combined with dilatation, a process constituting what may be denominated lithectomy, the object being to make a small opening in the first instance, which may afterwards, if necessary, be increased by pressure. The operation was originally suggested by Manzoni, of Verona, early in the present century, and has recently been warmly advocated by Dr. de Borsari, who seems to prefer it to every other expedient, on the ground of its freedom from hemorrhage and urinary infiltration, as well as the rapidity with which it may be executed, a single minute usually sufficing for its completion. The only instruments required are a staff, a bistoury, and a pair of forceps. Having made an incision

Fig. 570.



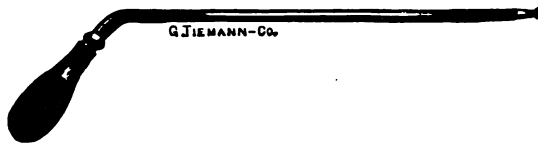
Lithotomy with the Rectangular Staff.

through the raphé of the perineum, de Borsa opens the whole of the membranous portion of the urethra, so as to expose the staff to the extent of about ten lines; when, laying aside his knife, he at once passes the left index-finger into the bladder, along the right side of the instrument, and then, by a semirotatory movement of the member, gently and cautiously conducted, he dilates the prostatic portion of the tube and the neck of the bladder sufficiently to enable him to introduce the forceps and extract the calculus. The operation is, of course, applicable only to small calculi.

A modification of this operation has been devised by Mr. George Allarton, of South Molton, England, who published an account of it in 1855. It consists in making an incision, with a long, straight bistoury, directly through the raphé of the perineum, about six lines above the verge of the anus, down upon a curved staff with a central groove, the instrument being previously hooked against the pubic symphysis, and well steadied by the left index-finger in the rectum. The knife, after having reached the staff, is carried a little towards the bladder, but not into it, when it is withdrawn, enlarging, as it retraces its steps, the external opening towards the scrotum, so as to make it altogether from an inch to an inch and a half in length. The operator then, inserting into the bladder a probe surmounted with a bulb, removes the staff, and expands the wound with the forefinger of the right hand. If the stone is small, it will now probably fall into the wound, and be forced down by the patient as he strains. Should this fail, the finger is again used, its size being increased by the addition of an India-rubber stall, until the dilatation has been carried to the required extent. If the calculus is rather large, it may be crushed; or, instead of this, the

prostate may be divided, as in the lateral section, a procedure, however, seldom necessary. The annexed cut, fig. 571, represents the director of Dr. J. L. Little, of New York, intended as a substitute for Mr. Allarton's probe, for guiding the finger and forceps into the bladder. It has a flat, tapering groove, with a blunt ex-

Fig. 571.



Dr. Little's Director.

tr extremity, and is about six inches in length, exclusive of the handle, which forms an angle with the blade of about 45°. The operation may be performed with an ordinary staff, or with the staff devised by Dr. Markoe, the groove of which is very wide, shallow, and continuous to the end of the instrument, so as to afford a larger surface to the knife, and admit the director to pass into the bladder without obstruction.

The advantages claimed for this operation are, 1st, that, as there are no large vessels encountered, there is less risk of hemorrhage than in the lateral section; 2dly, that no injury is inflicted upon the prostate gland and seminal vesicles; 3dly, that, as the deep perineal fascia is not invaded, there is no danger of urinary infiltration; 4thly, that it is more easy to maintain cleanliness during the after-treatment; and, 5thly, that the wound closes more rapidly than in the lateral operation. The disadvantages are, that the operation is more difficult of execution than the ordinary lateral one; that there is greater risk of wounding the rectum; and that it is not adapted to the removal of large calculi.

Mr. Allarton has collected 139 cases of this operation, of which 13, or 1 in 11, were fatal. The mortality, under twenty years, was 1 in 27; and, over twenty years, 1 in 7 cases. The registers of the Norfolk and Norwich Hospital show, up to the latter part of 1869, 64 cases with 13 deaths, or 1 in every 5. Under twenty years, 1 patient died out of 21; and above that age, 1 in every 3½. Of 96 cases of median lithotomy, in the hands of American surgeons, tabulated and analyzed, in 1870, by Dr. J. L. Little, including 12 of his own, only 3 died. All of the cases under twenty years, 59 in number, were successful; while the mortality above twenty years was 1 in 12½. These statistics afford an aggregate of 299 cases, with 29 deaths; or a loss of 1 in 10½.

Recto-Vesical Operation.—The recto-vesical operation, as devised in 1816 by Sanson, of Paris, has long been obsolete. It consists, as the name implies, in cutting into the bladder through the rectum, perineum, and prostate gland. It has been abandoned on account, chiefly, of its liability to be followed by extensive suppuration of the cellular tissue within the pelvis, injury of the ejaculatory ducts and seminal vesicles, and, lastly, although not least, stercoraceous fistule, difficult, if not impos-

sible, of cure. Of 83 cases of rectal lithotomy, analyzed by König, 16, or 1 in $5\frac{3}{16}$, perished. Eleven patients recovered with fistules.

A modification of this operation was successfully performed upon a man, twenty-six years of age, in 1859, by Dr. Louis Bauer, by opening the rectum just above the prostate, the canal having previously been expanded with a duck-bill speculum. The calculus, weighing an ounce and a half, was extracted with some difficulty. The wound was accurately closed with five silver sutures, which were removed on the eighth day, the union being perfect.

In a case operated upon, in 1860, by Dr. Noyes, the wound, made through the central portion of the prostate, and enlarged bilaterally, was closed with six metallic sutures, supported by a leaden button. The apparatus was removed on the twelfth day, the parts being entirely healed, except at one little point, which afterwards cicatrized under the application of nitrate of silver.

Supra-Pubic Operation.—In the supra-pubic, hypogastric, or high operation, the bladder is opened above the pubes, in the direction of the linea alba. Its chief advantages are, that it is free from hemorrhage; that it does not expose the patient to injury of the rectum and the ejaculatory ducts; that there is no risk from inflammation of the neck of the bladder; that it may be performed where the lateral section is impracticable; and, lastly, that it admits of the more easy removal of a large, attached, or encysted calculus. As an offset to these advantages, it is to be remarked that the procedure is liable to be followed by injury of the peritoneum, and by urinary infiltration, not to say anything of the difficulty of executing it when the abdomen is loaded with fat, or the bladder does not ascend any distance above the pubes. The latter of these dangers may, however, generally be avoided by premising a perineal puncture, to serve as an outlet to the urine, which thus drains off as fast as it reaches the neck of the bladder. The former, too, may usually be guarded against, if the precaution be used, first, to distend the bladder thoroughly before the operation, and, secondly, to push the peritoneum gently before the knife, after cutting through the inferior part of the linea alba.

In performing the operation, the patient is placed recumbent upon a narrow table, with the legs hanging loosely over its lower edge, and the feet resting upon a high chair. The head and shoulders are somewhat elevated, to relax the abdominal muscles. The bladder, previously freed of its contents, is filled with tepid water until it rises a considerable distance above the pubes. The surgeon, standing on the left side of the patient, makes an incision from three and a half to four inches in length, commencing at the pubic symphysis, and extending upwards towards the umbilicus, in the direction of the linea alba. It should pass through the skin and cellulo-adipose substance, down to the aponeuroses of the abdominal muscles. These structures, being thus exposed, are next cautiously divided to the same extent, any bleeding vessels being at once secured.

The bladder will be found at the bottom of the wound, forming a tolerably large, fluctuating tumor, invested merely by a thin layer of cellular tissue. To divide this, a few gentle touches of the knife are sufficient; or, what is better and more safe, the dissection may be effected with the steel end of the handle of the instrument. If the bladder is not sufficiently prominent, it should be rendered so by the introduction of a sound through the urethra. In either case, it is a matter of paramount importance to secure the organ with a tenaculum before it is incised, in order to prevent it from collapsing, and so sinking down behind the pubic bones; an occurrence which could not fail greatly to embarrass the subsequent steps of the operation. A puncture is next made into the anterior surface of the viscus, on a level with the pubic symphysis, large enough to admit the index-finger of the left hand, which is at once inserted, and used as a searcher, to ascertain the situation and volume of the stone. The opening is afterwards enlarged, with a probe-pointed bistoury, to any extent that may be required; the forceps are introduced, and the stone is seized and removed. A short silver tube, carefully rounded at the end, and pierced with numerous apertures at the sides, is now conveyed into the bladder, at the lower part of the wound, and secured by two pieces of tape fastened to a broad roller, the edges of the remainder of the opening being previously approximated by several points of the twisted suture, aided by adhesive strips.

Instead of the above procedure, which is often attended with much inconvenience and risk, the best plan is to close the wound in the bladder accurately by suture, introduced in such a manner as not to interfere materially with the serous investment

of the organ. The operation first practised, I believe, by Professor Bruns, of Tübingen, ought, in my judgment, to supersede the ordinary and more hazardous procedure.

The late Mr. George Bell, of Edinburgh, met with a remarkable, if not unique case, in which he successfully extracted several large calculi through a puncture above the pubes made originally for the relief of retention of urine caused by a greatly enlarged prostate gland. He dilated the track of the canula with sponge tents of gradually increasing size, and thus with a little patience and perseverance effected his purpose.

The supra-pubic operation was first performed, in this country, by Professor Gibson, of this city, his patient, an old man, dying in a few days of peritonitis, the effect of urinary infiltration. It was repeated, not long after, by Dr. Carpenter and Dr. McClellan. Of late years, it has been resorted to in a number of instances by some of our other surgeons, but not, on the whole, with any very gratifying results. The largest calculus ever removed by this method weighed upwards of two pounds, its length being nearly seven inches, its breadth four inches, and its thickness nearly two inches and a half. It was of a gourd-like figure, rough on the surface, and accurately moulded to the shape of the bladder, which was greatly indurated and hypertrophied. The patient, a man thirty-nine years of age, died on the eighth day of inflammation. The operator was Professor Uytterhoeven, of Brussels.

The most reliable statistics of the supra-pubic operation will be found in my Treatise on the Urinary Organs, comprising 180 cases, of which 39, or 1 in $4\frac{1}{2}$, proved fatal. The principal causes of death were peritonitis and urinary infiltration. Frère Côme lost 19 cases out of 100; Souberbielle 11 out of 39. Mr. Humphry, of England, lately collated the particulars of 104 cases of this operation, of which 31, or 1 in $3\frac{1}{3}$, proved fatal.

Inguinal, Scrotal, and Labial Lithotomy.—A urinary calculus is occasionally situated on the outside of the pelvis in a prolapsed bladder. The affection is most common in the groin, but instances have occurred in which the concretion descended into the scrotum, the sciatic notch, the labium, or even the perineum, as in the remarkable case related by Hartmann. The tumor which is thus formed may be of considerable bulk, especially when it is complicated with hernia of the bowel, and is either of very firm consistence, or soft at one point, and hard at another. Sometimes the stone is lodged partly within the pelvis, and partly on the outside.

The symptoms of extra-pelvic calculus do not differ materially from those which attend ordinary vesical calculus. The urine is voided with great difficulty, more or less pain is experienced, and little satisfaction is afforded by sounding. In general, the foreign body may readily be detected with the finger; when a number of concretions exist, a distinct crackling noise may occasionally be elicited by rubbing them against each other.

The proper treatment in these different forms of calculus consists in cutting down upon the foreign substance, through the coats of the prolapsed bladder, as it lies in its abnormal situation, in effecting extraction with the finger, scoop, or forceps, and in retaining a catheter in the bladder until the wound is nearly healed, lest urinary infiltration should occur. When the concretion projects by its large extremity into the pelvis, it may be necessary to perform the lateral or supra-pubic operation, as riddance by direct incision will then probably be impracticable. It is not improbable that the healing of the wound in the bladder might be facilitated after this operation by the use of the suture.

GENERAL RESULTS OF THE DIFFERENT METHODS OF LITHOTOMY.

The following table presents the general results of the more important operations described in the preceding pages.

Methods.	Cases.	Cures.	Deaths.	Ratio of deaths.
Lateral operation	8509	7444	1065	1 in 8
Bilateral "	228	195	33	1 in $6\frac{2}{3}$
Median "	209	270	29	1 in $10\frac{1}{2}$
Recto-vesical "	83	67	16	1 in $5\frac{1}{5}$
Supra-pubic "	180	141	39	1 in $4\frac{1}{4}$
Total	9209	8117	1182	1 in $7\frac{1}{2}$

STONE IN THE BLADDER OF THE FEMALE.

Women are much less liable to urinary calculi than men. The period of life at which they are most prone to suffer is from the twentieth to the fiftieth year. The symptoms which attend the affection, and the effects occasioned by it, are similar to those which characterize it in the other sex.

Stone in the female forms more frequently than in the male upon foreign bodies, either developed there or introduced from without. Dr. James Morton, of Scotland, has published the particulars of a case in which he removed, by the lateral operation, from a woman, forty-seven years of age, three calculi and a bone, evidently the sequel of an extra-uterine conception. Similar instances have been recorded by Blackman, Humphry, and others.

A stone in the bladder may be so large as to interfere with parturition by preventing the descent of the child's head. The complication thus produced may prove serious, as in the interesting case related by Mr. Thralfall, of Liverpool, where, from the true cause of the obstruction not being detected, the woman was permitted to die undelivered.

In sounding, the patient is placed upon her back, on the edge of the bed; and the instrument, a short steel rod, slightly curved at the extremity, is carried about through the interior of the bladder, so as to explore, if necessary, every recess of this organ. In young children, the finger may, if deemed advisable, be inserted into the rectum; but in grown subjects it is always best to introduce it into the vagina.

A number of cases have been recorded in which calculi of large size were spontaneously expelled from the female bladder. The extrusion is sometimes effected suddenly, but generally it is accomplished slowly, and with more or less pain and difficulty in voiding the urine. Dr. Walter F. Atlee recently showed me a rough, ovoidal calculus, three-quarters of an inch in its smallest diameter, voided by a woman, forty-five years of age, after it had been detained in the urethra for four hours. A little effort with the finger was necessary to complete the extrusion. Slight incontinence of urine followed, but disappeared in a very short time. Cases of the spontaneous expulsion of stones, weighing from two to twelve ounces, have been recorded by Callot, Molyneux, Yelloby, Middleton, Klauder, Botti, and others.

A vesical calculus is sometimes discharged through the vagina, in consequence of ulceration of the vesico-vaginal septum. In a case of this kind, mentioned to me by Dr. Dunlap, of Norristown, a woman, sixty-seven years of age, after eight days of intense suffering, was rid in this manner of a stone weighing three ounces, and measuring upwards of three inches in its long diameter. It was of an ovoidal shape, of a lamellated structure, and of a phosphatic character. For some time most of the urine passed off at the abnormal opening, and nearly twelve months elapsed before it fully resumed its natural route. Two years and a half afterwards, Dr. Dunlap removed two small calculi with the forceps. The woman is now seventy-five years of age, and there is still slight dribbling of urine when she is in the erect posture.

The common plans of operation, for the removal of stone from the female bladder, are dilatation of the urethra, crushing, and incision.

The method by *dilatation* is liable to be followed by incontinence of urine, on which account it has fallen very much into disrepute. It is more particularly adapted to small concretions, unaccompanied by any serious disease of the urethra

Fig. 572.



Urethral Dilator.

and the neck of the bladder, although calculi two inches in diameter have been removed, and even spontaneously expelled, without any resulting inconvenience. The dilatation is best effected rapidly, by means of instruments especially contrived for the purpose, as the one sketched at fig. 572, or by sponge tents. When the stone is small, the necessary dilatation may be effected in a few moments with the ordinary polyp-forceps.

Crushing may be employed when the stone is comparatively soft, and yet so large as to render it impossible to extract it without undue dilatation of the urethra. The object may be effected either with a small pair of lithotomy forceps, rather narrower than common in the blades, or with a short lithotrite.

The operation of *lithotomy* is easy of execution, perfectly free from danger of hemorrhage, and not liable, when properly performed, to be followed by incontinence of urine. The only instruments that are required for its performance are a straight staff, five inches in length, and a straight probe-pointed bistoury. The staff, fig. 573, being introduced, an incision is made directly upwards towards the pubic symphysis,

Fig. 573.



Female Staff.

extending through the urethra and the neck of the bladder, in their entire length. The opening may afterwards, if necessary, be dilated with the finger to almost any extent that may be required for the safe and easy extraction of the calculus. When the concretion, however, is of unusual magnitude, and cannot thus be removed, the incision may be extended downwards and outwards towards the tuberosity of the ischium.

A modification of the above operation, consisting of dilatation and incision, may sometimes be advantageously employed. After dilatation has been practised to a sufficient extent to admit the index-finger, the tube is divided in one-half of its length, either anteriorly or posteriorly, according to the judgment of the surgeon. The great object of this procedure is to prevent incontinence of urine.

A stone has sometimes been extracted through an incision in the anterior wall of the vagina, constituting what is called vesico-vaginal lithotomy. The operation, originally performed by Rousset, is extremely easy of execution, but, inasmuch as it is liable to be followed by fistule, it cannot be too pointedly condemned. Should the necessities of the case render such interference indispensable on account of the large size of the calculus, disease of the vulva, or obstruction to the passage of the child's head in parturition, the edges of the wound should immediately be approximated by wire sutures.

The greatest attention should be paid to the after-treatment in lithotomy in the female. No matter how simple the operation may be, the strictest recumbency should be observed not only until the parts are partially healed, but until they have, in great degree, fully regained their natural tone. When this point is properly attended to, there is little danger of incontinence of urine. Even a stone of immense size may, with such precautions, be occasionally removed with perfect safety as it respects this unpleasant occurrence, as is shown in the remarkable case of the late Dr. J. Kearney Rodgers, of New York, where the calculus weighed upwards of nine ounces, and was nearly ten inches in circumference, and yet no ill effects whatever ensued.

FOREIGN BODIES IN THE BLADDER.

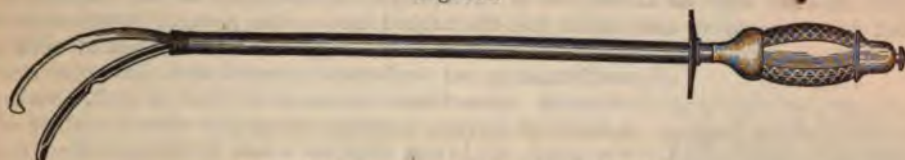
Various foreign bodies, such as balls, pins, needles, fragments of bone, pieces of straw, or other vegetable substances, and bits of catheters and bougies, may find their way into the bladder either accidentally, or designedly, with the hope of relieving pain or for the purpose of gratifying the venereal appetite. However this may be, the effects upon the foreign substance and the bladder are generally similar, or, if they differ at all, they differ only in a very slight degree. The extraneous body is usually very speedily incrustated with earthy matter, sometimes attaining a large bulk in a few months. Occasionally it perforates the bladder and, escaping into the

peritoneal cavity, excites fatal inflammation. The likelihood of such an occurrence will, of course, be greatly influenced by the form and consistence of the foreign substance.

The extraneous body, if small, may be expelled spontaneously; but, generally speaking, it must be extracted by operation. A bullet of ordinary size might be removed simply by dilating the urethra; or, this failing, with Cooper's forceps. When the foreign body refuses to come away of its own accord, or the forceps are unavailing, relief must be attempted by the lateral operation.

The records of surgery abound in instances in which bits of gum-elastic catheters and bougies were extracted from the bladder by means of short-bladed lithotrites, or forceps, an excellent pair of which is represented in fig. 574. When the prostate

Fig. 574.



Forceps for Extracting Foreign Bodies from the Bladder.

gland is much enlarged and the bladder greatly dilated, removal by the natural channel is sometimes very difficult. In a case of this nature, in a man, sixty-three years of age, failing to effect riddance with the lithotrite, I finally succeeded, after a preliminary median incision, in extracting, with a long brass bullet probe, bent at nearly a right angle, a No. 12 conical bougie, which lay in a pouch behind and to the left of the prostate. When the foreign body is a pin or needle, it may sometimes be entrapped in the eye of a catheter, as in the memorable case of La Motte. Dr. H. L. W. Burritt recently reported a case in which a piece of bougie, three inches in length, was expelled from the bladder, after previous dilatation of the urethra, under the influence of a full stream of urine, retained only for four hours.

In gunshot wounds of the bladder the ball, if retained, generally becomes speedily incrustated with sabulous matter, and produces all the symptoms of ordinary calculus. The only remedy is excision, an operation first performed by the celebrated lithotomist, Frère Jacques, in 1698. Ballingall has collected nineteen cases of this kind. Of thirteen cases analyzed by Dixon, ten recovered, and three died. In a case operated upon by the lateral section, in 1871, by Professor McGuire, of Richmond, the foreign mass weighed upwards of one ounce. The concretion, composed of triple phosphates, had undergone spontaneous fracture.

Foreign bodies in the bladder of the female generally admit of much more easy removal than in the other sex, owing to the greater brevity and dilatability of the urethra. The best plan is to effect rapid dilatation with the bougie and finger, while the patient is under the influence of chloroform, and then to seize the extraneous substance with a pair of delicate lithotomy forceps. When the ends are very sharp, or infixed in the walls of the bladder, the procedure must be conducted with unusual care, otherwise the organ may be seriously lacerated. Under such circumstances it is sometimes best to combine dilatation with incision.

Cases in which pessaries were introduced into the bladder, either by mistake or design, have been reported by H. R. Storer, Byford, Edwards, Woolen, and others. Removal should, if possible, be effected through the urethra, the foreign body being crushed, if necessary, to promote its passage. If the attempt fail, the dilatation of the urethra should be combined with incision, as in lithotomy. Extraction through the vagina is objectionable, as it is liable to be followed by obstinate, if not incurable, fistule. Should this procedure, however, be deemed indispensable, then the proper plan certainly would be to close the wound immediately with wire sutures, as in the ordinary operation for vesico-vaginal fistule.

SECT. III.—DISEASES AND INJURIES OF THE URETHRA.

MALFORMATIONS.

The urethra is liable to a variety of malformations, which, although exceedingly rare, ought, nevertheless, to be well understood, on account of their great practical

importance, and the sad effects which they exert upon the happiness of the poor sufferer. The most common of these congenital vices are, first, closure or contraction of the meatus; and, secondly, absence, contraction, and change of form of the urethra.

The external orifice of the urethra occasionally deviates from its normal situation, lying much higher up or lower down than usual; and cases occur where it is either extremely small, or altogether occluded, thus interfering more or less completely with the passage of the urine, and becoming a source of vesical disease, as cystitis, irritability, and urinary calculus, or symptoms simulative of stone and other functional disturbance. I have met with several instances of double meatus, in neither of which, however, more than one opened into the urethra, the other ending in a blind pouch.

The urethra may be absent, as is exemplified in exstrophy of the bladder, in which both the urine and semen are discharged above the pubes. Authors have described what is called a double urethra, but of such a malformation no well-authenticated case has ever been reported. Sometimes the canal is bifid or cleft, forming a kind of gutter, running along the dorsal surface of the penis, and constituting what is denominated *epispadias*, as seen in fig. 575. Occasionally, again, it is deficient in front, but well formed behind, terminating, however, always in a narrow orifice, admitting of an imperfect discharge of the urine. It is to this variety of malformation that the term *hypospadias* has been applied.

Some of these defects are, of course, irremediable; others, however, admit of relief, although generally not without great difficulty.

Occlusion of the external meatus always demands prompt interference. When it is caused simply by a duplicature of the lining membrane, forming a sort of hymen, a vertical incision in the direction of the natural outlet is generally all that is required, the edges of the wound being kept asunder by means of a bougie. When

the imperforation depends upon the presence of fibrous tissue, and reaches a considerable distance back, the operation will be more serious, and will require to be performed with a trocar.

Hypospadias and epispadias are defects of a serious character, which, besides greatly inconveniencing their unhappy subjects, often serve as causes of impotence.

Hypospadias occurs under three varieties of form, of which the most common, as well as the most simple, is the one in which the urethra opens immediately behind the frenum; in the second, the tube opens at some point immediately between the first and the scrotum; and in the third, the urethra terminates at the latter organ, which is cleft at the middle line.

In the more simple variety of *hypospadias*, a cure may be attempted by paring the edges of the fissure and uniting them by means of interrupted sutures over a catheter introduced into the bladder. Any part that may remain unclosed may be touched with nitrate of silver.

The same mode of proceeding is adopted when the fissure exists farther back, only that it will be necessary, in addition, to establish an artificial urethra by means of a trocar, pushed in the direction of the natural channel. The canal is kept pervious by a catheter, until it has received a mucous lining, after which the instrument should be worn for a few hours every day for a number of months.

The treatment for the relief of *epispadias* is conducted upon the same principle as in *hypospadias*. In a case reported by Liston, in which nearly four inches of the urethra were exposed, a complete cure was effected in a few days. The operation consisted in paring the edges of the cleft thoroughly, and drawing them together over a catheter, by means of many points of the twisted suture. Union by the first intention took place in the entire track, except near the pubes, where a very minute fistulous opening remained, through which not more than a drop of urine oozed during micturition. This was afterwards closed with a heated needle. The organ was, in all respects, and for all purposes, as perfect as could be desired.

Fig. 575.



Epispadias.

WOUNDS AND LACERATIONS.

Wounds of the urethra may be incised, punctured, lacerated, contused, or gunshot, as in other parts of the body, and they are either serious or otherwise, according to their extent and the absence or presence of complications. The treatment must be conducted upon general principles, accurate apposition of the edges being effected, if possible, by suture and collodion, and the escape of urine prevented by the use of the catheter permanently retained, or, what is preferable, inserted several times in the twenty-four hours. Gunshot wounds of the urethra are always dangerous, inasmuch as they are very liable to be followed by urinary infiltration and permanent fistules.

The tube may be ruptured by causes acting either from without, or from within. Under the first head may be comprised falls, blows, and kicks upon the perineum, or the perineum and penis; under the second, injury done by the lodgment of a calculus, the violent straining which attends micturition in stricture, and the rude, forcible, or injudicious use of catheters, bougies, and sounds.

Laceration of this canal occasionally occurs under a violent erection, especially if the penis, while in this condition, be struck accidentally against a hard, resisting body. The accident has also been known to happen during coition and during convalescence, after attacks of fever. The rent may be limited to the mucous membrane, or it may involve along with it all the tissues which intervene between the canal and the external surface.

The symptoms are generally sufficiently characteristic. The most prominent are, pain in the affected part, hemorrhage, inability to void the urine, or the discharge of this fluid in a small and imperfect manner, discoloration of the perineum, or of the perineum, scrotum, and penis, and great difficulty, if not impossibility, of introducing the catheter. The patient is weak and faint, perhaps sick at the stomach, and labors under all the effects of severe shock.

The treatment must be prompt and decisive, as there is great danger of infiltration of the cellular tissue of the perineum and scrotum, from the escape of urine. If the rent be small, the first thing to be done is to pass a catheter into the bladder, one being selected that is rather over than under the ordinary size. If, on the contrary, the injury is very extensive, or if some hours have elapsed since its occurrence, and the symptoms indicate urinary infiltration, numerous and deep incisions should at once be made into the affected parts. In conjunction with this treatment, local bleeding, purgatives, the warm bath, anodynes, fomentations, and poultices may advantageously be employed.

HEMORRHAGE.

Hemorrhage of the urethra occurs under two varieties of form, the spontaneous and traumatic, of which the latter is the more frequent. The spontaneous form is met with chiefly in elderly and middle-aged persons, of irregular, dissolute habits. It occasionally occurs during a violent erection of the penis. Traumatic hemorrhage, on the contrary, usually depends upon direct violence, as the passage of a urinary concretion, the introduction of instruments, or attempts to force a stricture. It is a very common consequence of injury of the perineum. The bleeding, however induced, is seldom copious.

Hemorrhage of the urethra rarely requires surgical interference; in most cases it either ceases spontaneously, or it is easily arrested by repose in the horizontal posture upon a hair mattress, by iced drinks, and by pressure, for a few minutes, upon the perineum, directly opposite to the part from which the blood proceeds. A cold enema sometimes puts a sudden stop to it. Ice applied to the perineum, and cold and astringent injections into the urethra, thrown high up, are very beneficial. When the case is obstinate, compression may be made by means of a large catheter, introduced into the bladder, and supported with a bandage, a finger, or adhesive strips. The most efficient internal remedies are gallic acid and subacetate of lead, in combination with opium. Alum, given in large doses, is also useful. In very obstinate cases, recourse may be had to spirit of turpentine and tincture of the chloride of iron, in doses of ten drops each, repeated every hour.

FOREIGN BODIES.

Foreign bodies in the urethra may be arranged under two heads: 1st, those which descend from the urinary bladder, or which are developed in the canal itself; and, 2dly, substances forced into the urethra through its natural orifice.

1. *Foreign Bodies which descend from the Bladder, or are developed in the Urethra.*—Most of the substances which descend into the urethra from the bladder are simply earthy concretions, which are developed either in the latter organ, in the prostate gland, or in the kidneys. Sometimes, however, they consist of articles which were originally admitted through the urethra, and which have afterwards, in consequence of the force impressed upon them by the bladder in micturition, taken a retrograde course. The concretion may be developed in the urethra itself, but this is rare.

The passage of a calculus from the bladder along the urethra is frequently productive of great inconvenience and distress. The intromission is generally sudden and unexpected, taking place while the patient is engaged in micturition. It is instantly followed by an interruption of the stream of urine, an urgent desire to empty the bladder, severe straining, more or less pain, and a sense of burning or tearing in the urethra. If the substance is small, it may be expelled in a few minutes; if, on the contrary, it is disproportionately bulky, it may be permanently arrested, and give rise to severe suffering, accompanied by retention of urine, painful erections, and probably, also, by slight hemorrhage from laceration of the mucous membrane.

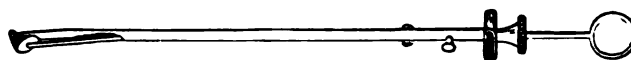
The symptoms attending the passage of a calculus along the urethra may be simulated by other affections; therefore, to establish the diagnosis it is necessary to institute a careful examination with the finger and the catheter. When the substance is situated far back, as in the membranous or prostatic portion of the canal, the finger must be inserted into the rectum. In using the catheter, care should be taken that the substance be not pushed into the bladder. It is worthy of remark that, when the calculus has escaped from the urethra and lodged in the subjacent structures, the instrument may fail to detect it, even when it is of considerable size.

A calculus, after having remained in the urethra for an indefinite period, sometimes effects its own expulsion by exciting absorption, and, finally, ulceration of the surrounding tissues.

When the foreign body is lodged in the posterior portion of the tube, and obstructs the flow of urine, the safest plan is to push it back into the bladder; whereas, if it is comparatively small, or unusually rough, it should be removed. Before doing this, however, an attempt should be made to favor its expulsion by dilating the urethra. Occasionally extrusion may be effected by injections of sweet oil, or by closing the prepuce, and holding it tightly while the patient is making a powerful effort at micturition, at the same time that pressure is applied along the under surface of the urethra, to urge on the foreign body.

When the calculus occupies the spongy portion of the tube, it ought to be extracted, whatever may be its size or form, provided it cannot be extruded during micturition. When it is situated near the orifice of the urethra, it may readily be removed with a pair of narrow-bladed dissecting forceps, but if it be far back in the canal, a wire-loop, as originally suggested by Marini, may be used. The only objection to this instrument is the difficulty of passing it behind the concretion, which, when large enough to lodge, usually fills up the entire passage. Professor Hodgen, of St. Louis, published, in 1868, the particulars of two cases, in which he promptly effected removal of the foreign substance with a contrivance of a similar kind.

Fig. 576.

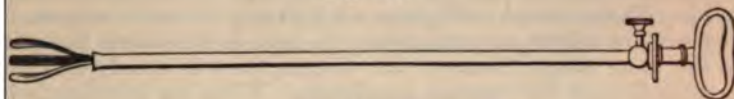


Bonnet's Articulated Scoop.

When these simple means fail, recourse must be had to the urethral forceps, of which there is a great variety. The one to which I give the preference is the articulated scoop, fig. 576, of Bonnet, of Lyons, but it is applicable only to small substances. It is armed with a stylet, and is furnished with a head for seizing and fix-

foreign body. The instrument, well oiled, is brought in contact with the body, when its blades are expanded over it, and extraction effected in the most gentle manner, to prevent injury of the mucous membrane. Fig. 577 represents Hunter's forceps, as improved by modern surgeons, for removing urethral

Fig. 577.



Hunter's Forceps.

Fig. 577 is applicable only when the calculus is soft and friable; but as this can never be known beforehand, it is rarely available. The operation, moreover, is not safe.

When the calculus is hard, an operation, which becomes necessary when extraction fails, varies according to the position of the foreign body. When the concretion is lodged in the prostatic or bulbous part of the tube, it is performed very much after the manner of Celsus, viz. on the gripe, the left index-finger being inserted into the rectum, to produce pressure from behind, and a small incision being made in the direction of the urethra towards the perineum.

If the calculus is impacted in the navicular fossa, or even farther back, its extraction may generally be easily effected with the forceps represented in fig. 578. In such a case, an incision may be made over it, along the floor of the urethra, opposite to the penis.

Fig. 578.



Forceps for Extracting Foreign Bodies from the Urethra.

If the foreign body lies in the scrotal portion of the urethra, incision must be made with great caution, lest it be followed by infiltration of urine, and all the consequences of such an accident. In such a case, it would be advisable to close the wound immediately with nitrate of silver, to favor the deposit of lymph, and to abstain from micturition until the parts are thoroughly consolidated. Or, if this fails, an incision might be made through the skin and cellular tissue over the urethra, and the wound stuffed with lint. The requisite amount of inflammation being excited, the operation is completed by dividing the parietes of the urethra in the usual manner.

Foreign Bodies introduced from without.—Of foreign bodies introduced into the urethra from without, the number and variety are quite considerable. The occurrence is sometimes fortuitous, but more frequently it takes place through design. Catheters, bougies, quills, pipe-stems, wood, straw, and other substances, have been accidentally lodged in the urethra, by persons in their endeavor to draw off the urine, to relieve a stricture, or provoke onanism.

Foreign bodies, introduced into the urethra from without, have a great tendency to pass into the bladder, owing to the suction power of this organ. Very frequently, they become impacted in the tube, and they may then, unless they are situated far back, be usually readily extracted with a pair of delicate forceps, such as those represented in fig. 578.

MORBID SENSIBILITY.

Urethral affection consists mainly, if not exclusively, in an exaltation of the natural sensibility of the mucous membrane of the urethra. It is very frequent in both

sexes, but much more so in men than in women, and is caused by a great variety of circumstances, not always easy of recognition. In the male it is often dependent upon the effects of gonorrhœa and gleet, stricture of the urethra, and enlargement of the prostate gland; and, in both sexes, upon disorder of the bladder, kidneys, ureters, anus, and rectum. It sometimes attends inflammation, ulceration, and other derangement of the uterus, vagina, and vulva. A morbid state of the urine may not only induce it, but maintain it for an indefinite period. Of all the causes, however, onanism and inordinate sexual indulgence are probably the most common.

The symptoms are subject to great diversity, both as it respects their nature and degree. In the more simple forms of the disease, there is merely an exaltation of the normal sensibility of the mucous membrane. When the affection is more fully developed, the local distress is not only more severe but it often extends to the surrounding parts, as the perineum, groin, anus, pubes, and genital organs. The bladder also suffers, sometimes sympathetically, and at other times from actual extension of the disease. Occasionally the symptoms simulate those of stone in the bladder. When the disease exists in this aggravated form, there is always marked disorder of the general health. When the posterior portion of the tube is involved, seminal emissions are apt to take place. The urine is variously altered in its properties; in general, it contains an undue quantity of mucus, and not unfrequently it exhibits, under the microscope, different deposits, especially oxalate of lime and phosphates.

The best mode of determining the precise nature of this disorder is the introduction of the catheter. One of medium size is selected, and is passed with the greatest care and gentleness. By this means we are able to ascertain the extent and degree of the sensibility, and also whether there is stricture of the urethra, enlargement of the prostate gland, or disease of the bladder. It should be remembered that the healthy urethra is often so extremely sensitive on the first introduction of a catheter as to cause severe shock, if not actual syncope.

The pathology of this disease is not accurately ascertained. It is no doubt occasionally caused by inflammation, either subacute or chronic; but very frequently it consists merely in an exaltation of the normal sensibility of the mucous membrane.

In the treatment of this affection, one of the first objects should be to ascertain and remove the exciting cause. Marked relief commonly follows the use of bicarbonate of soda, either alone or in union with uva ursi and hop tea, mild laxatives, and anodyne injections, with the addition of a small quantity of Goulard's extract. The general health should be attended to. The introduction of a full-sized catheter, at first once and afterwards twice a day, is sometimes productive of the best results. In this way, moreover, the affected surface may be directly medicated; the dilute ointments of nitrate of mercury and belladonna are, especially if used in combination, entitled to the first rank in the list of this class of remedies. When there are involuntary seminal emissions, hardly anything short of cauterization of the prostatic and membranous portions of the urethra will be likely to succeed. Whatever mode of treatment be adopted, the patient should refrain from sexual indulgence and exercise on horseback. Opiate suppositories often afford great relief.

The best internal remedy, when there is no appreciable local cause for the disease, is, on the whole, the bromide of potassium, given in solution, in doses of twenty to thirty grains three times a day. It seems to act as a sedative, and to make a direct impression upon the affected parts.

NEURALGIA.

Neuralgia of the urethra is most common soon after the age of puberty, in persons of a nervous, excitable temperament. It is much more frequent in males than in females. Its origin is generally obscure. External injury, onanism, and venereal excesses are among the most common exciting causes. It is sometimes dependent upon a miasmatic condition of the system.

The pain is of a sharp, pricking character, darting about in different directions with the rapidity of lightning; it often remits or intermits for a few seconds, and then recurs with its former violence; it is generally attended with considerable soreness of the urethra and penis, a frequent desire to micturate, and scalding in voiding urine. In some cases the disease is periodical.

The treatment is to be conducted in the same manner as neuralgia in other parts of the body. The cause is, of course, if possible, removed, after which recourse is had to

quinine, arsenic, strychnia, and aconite. When the affection is of a purely miasmatic origin, no other treatment is generally required. In the milder forms of the disease, quinine alone will often speedily effect a cure. In obstinate cases, valerianate of iron sometimes succeeds when all other remedies fail.

Little is necessary in the way of local treatment. During the paroxysm, the penis may be immersed in warm water, or fomented with hot cloths impregnated with laudanum. An ointment of veratria and belladonna, and the use of a thick flannel stall to protect the penis from atmospheric vicissitudes, are occasionally of service. It need scarcely be added that all sexual excitement should be avoided.

POLYPOID TUMORS.

These tumors occur in both sexes, and in different portions of the urethra. In the male, the most common site is the anterior part of the tube, just behind the meatus. In women they are generally situated superficially, sometimes projecting beyond the external orifice of the urethra.

In the male, these growths are usually small, their volume rarely exceeding that of an apple-seed. They are of a soft, spongy consistence, of a red color, and of a pyriform, conical, or spherical shape, their attachment being usually by a small pedicle. In general, they are solitary, but I recollect one instance in which there were not less than three, situated close together. Their surface is sometimes perfectly smooth, at other times slightly granular, rough, or studded with papillæ. In regard to their structure, they consist of a fibroid, or cellulo-vascular substance, invested by a prolongation of the lining membrane of the urethra. A good idea of this variety of morbid growth is afforded by fig. 579, from Thompson.

These polypoid tumors are generally free from pain, in which respect they differ remarkably from the vascular papillary growths in and around the female urethra. They are usually attended by a thin, gleet discharge, but they seldom materially obstruct micturition. Their development is tardy and insidious, and they do not often manifest any disposition to reappear after extirpation. When deep-seated they may exist for years without the possibility of detection.

The removal of these excrescences is best effected by excision with the knife or scissors. The surface should always be touched immediately after with nitrate of silver or sulphate of copper. When situated low down in the urethra, they may sometimes be caught in the loop of a silver wire, especially if they have a very narrow pedicle.

Fig. 579.



Polyp of the Urethra.

SPASMODIC STRICTURE.

Stricture of the urethra occurs under two very distinct forms, the spasmodic and organic, or the transient and permanent. What has been called the inflammatory stricture, an affection still recognized by some authors, is simply an impediment to the flow of the urine, caused by a congested and irritated condition of the canal, attended, in rare cases, by cellular proliferation upon the free surface of the mucous membrane, such, for example, as occasionally happens in a severe attack of gonorrhœa. It is not, strictly considered, a stricture, although it is liable to be attended with spasmodic action. A congestive stricture has been described, dependent, as has been alleged, upon an engorged condition of the capillary vessels of the lining membrane and connective tissue, thereby leading to a diminution of the urethra with consequent difficulty of micturition.

The possibility of the occurrence of a spasmodic stricture of the urethra has been denied by many able writers and practitioners. A recent English author, in speaking of it, says: "I will tell you what a spasmodic stricture is. It is exceedingly useful as an excuse for the failure of instruments. It is a refuge for incompetence." Others, on the contrary, strenuously insist upon the reality of such a stricture; and,

considering how frequently it is met with, it is only surprising that there should be any difference of opinion respecting it. Other mucous canals are liable to this form of stricture, and there is no reason, anatomical or physiological, why the urethra should be exempt. Spasmodic stricture of the œsophagus is of frequent occurrence, especially in nervous, irritable females; vaginismus, so well described by Dr. J. Marion Sims, is a spasmodic contraction of the vagina, interfering with copulation; and in fissure of the anus one of the most distressing symptoms is spasmodic stricture of the sphincter muscles. Spasmodic stricture of the larynx often causes instantaneous suffocation. It is not surprising that the urethra should be subject to this form of stricture when it is remembered that it is completely encircled, from one extremity to the other, by muscular fibres, not to insist upon the fact that, in certain conditions of the genito-urinary apparatus, it must be influenced, in a greater or less degree, by the action of the accelerator muscles and by the muscles of Wilson and of Guthrie, which so closely embrace the posterior portion of the canal. Every surgeon knows how firmly a bougie is sometimes grasped by the urethra, and how easily a spasmodic stricture is generally overcome by the mere contact of the catheter in retention of urine, the fluid beginning to flow long before the instrument has reached the bladder.

The causes of spasmodic stricture of the urethra are of a very diversified nature. Among the more prominent are, sudden suppression of the cutaneous perspiration, especially in persons of a rheumatic, gouty, neuralgic, or scrofulous predisposition; venereal excesses and self-abuse; disease of the urethra, bladder, prostate gland, ureters, and kidneys; calculous affections; vitiated renal secretions; the lithic, oxalic, and phosphatic diatheses; reflected irritation from the anus and rectum, as in hemorrhoids, fissure, and fistule; disorder of the digestive apparatus; spinal irritation; mental excitement from an overworked brain; and intemperance in eating and drinking. One of the worst cases of spasmodic stricture of the urethra that I have ever met with occurred in a young man, the subject in early life of coxalgia, from drinking a glass of champagne, the attack being sure to recur whenever he indulged in that way. Similar effects occasionally follow the use of red wine, punch, malt liquors, and high-seasoned food. A long residence in a tropical climate conjoined with free living exerts a powerful predisposition to the complaint. In the female spasmodic stricture of the urethra is frequently produced by reflex irritation from the uterus, in dysmenorrhœa, malpositions, and carcinomatous disease of that organ.

The pathology of this variety of stricture is not easily determined. The probability, however, is that it generally depends upon mere irritation of the muscular fibres of the urethra, attended, perhaps, by temporary congestion of its various component structures. In the so-called inflammatory stricture the vascular engorgement is doubtless more persistent, and often associated with inflammatory deposits.

The spasmodic stricture is essentially characterized by a narrowing of the urethra, attended with painful and difficult micturition. The contraction is commonly limited to some particular portion of the canal, and the membranous is the one which is most liable to suffer, probably because it is naturally the narrowest, and embraced by voluntary as well as involuntary muscular fibres. Cases, however, occur, although they are rare, in which the contraction apparently pervades the entire tube. The attack usually comes on suddenly, generally from exposure to cold, in which the surface of the body has been severely chilled, the inordinate use of wine, stimulating food, or excessive sexual indulgence, especially if the genito-urinary organs have already been in an irritable condition. The patient, on attempting to empty his bladder, finds that he can void only a few drops of urine at a time, or that the fluid passes off in small, feeble jets, without affording him any decided relief. The effort is attended with great straining and tenesmus, along with a feeling of weight and uneasiness in the perineum and anus, and there is more or less scalding along the neck of the bladder and the whole length of the urethra, often so great as almost to convulse the system. As soon as the bladder is completely emptied, the contraction generally subsides, to recur perhaps, with its former, if not increased, violence, the moment almost that the urine begins to reaccumulate; and thus the attack may continue for hours and even days, with occasional complete intermissions of suffering. When the stricture is very severe, and prompt relief is not obtained, symptomatic fever arises, the skin becomes hot and dry, the pulse is excited, and there is more or less thirst, with disorder of the secretions, restlessness, and loss of sleep. The urethra is generally entirely free from discharge, except in

is complicated with, or directly dependent upon, inflammation, when there may be more or less purulent secretion, accompanied with swelling and discoloration of the edges of the meatus. Occasionally painful and annoying erections are present. The treatment is palliative and radical. The first thing generally to be done is to ease the bladder, the spasm usually subsiding the moment the organ is completely relieved. The most efficient remedies are anodynes, the warm bath, and hot applications to the hypogastrium, perineum, and genitals. A hypodermic injection of opium generally affords the most speedy relief. Dover's powder and laudanum are highly beneficial. Sometimes nothing answers so well as the passage of a catheter, well warmed and oiled, and carefully introduced as far as the seat of obstruction, which often yields the moment the contact is effected, the urine coming in a full stream, followed by instantaneous relaxation of the parts. The radical treatment is based upon the removal of the exciting causes of the complaint, and the improvement of the general health, by a proper regulation of the diet, attention to the bowels and secretions, suitable clothing, and exercise in the open air, aided, if there be an anemic condition of the system, dyspepsia, or general debility, by a course of chalybeate tonics, cold bathing, and frictions with the flesh-brush. All stimulating food and drink, and all kinds of excesses must be carefully avoided, as they are so many exciting causes of the disorder.

ORGANIC STRICTURE.

Organic stricture is a permanent obstruction, depending upon the formation of fibrous tissue elements in the component structures of the urethra, where they give rise to a dense, resisting, cicatricial substance, which, encroaching more or less seriously upon the caliber of the passage, thus cause a corresponding obstacle to the evacuation of the urine and the introduction of instruments.

Organic stricture presents itself in various forms and degrees. Thus, it may be simple or complicated, common or traumatic, partial or complete, soft or callous, indurated or undilatable, permeable or impermeable, recent or old; terms which sufficiently explain themselves. Much diversity prevails in relation to its seat, number, degree, consistence and extent.

No part of the urethra, except, perhaps, the prostatic, is entirely exempt from this disease. My experience is that the affection is most common, first, in that portion of the urethra which is comprised between the scrotum and the head of the penis; secondly, at the membranous part of the tube, or at the junction of this and the spongy part; and, lastly, at the anterior extremity within a few lines of the meatus. Stricture at the prostatic portion of the canal has been found only in a very few instances. The anterior orifice suffers occasionally, as a result of chancre.

The seat of this disease has been very carefully examined by Mr. Henry Smith and Sir Henry Thompson. According to the former, it is most common in the bulb, just in front of it, and about equally frequent in the membranous and spongy portions, and very rare at the meatus. The number of specimens inspected by the latter observer was 270, embracing 320 distinct strictures. Of these, 215, or 67 per cent. of the entire number, were situated at the junction of the membranous and spongy portions and its vicinity; 51, or 16 per cent., in the centre of the spongy portion; and 54, or 17 per cent., at the external orifice, and within two inches and half behind this point. In 226 cases, the stricture was single, and in 185 of these was situated at the first locality, and in 24, in the anterior part of the spongy portion.

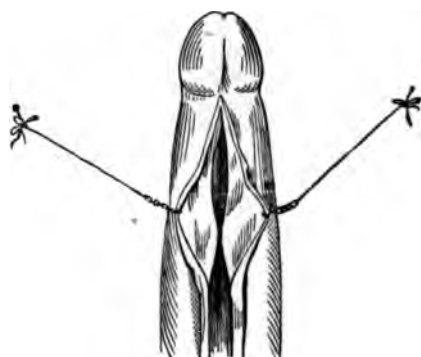
In most cases, there is only one stricture; frequently, however, I have seen two, occasionally, but very rarely, three, and even four. Hunter met with an instance of six, Lallemand of seven, Colot of eight.

One of the most common forms of stricture is that in which the urethra exhibits the appearance as if a thread or piece of twine had been tied around it. It may embrace the entire circumference of the tube, as in fig. 580, or only a part of it, and extend in its antero-posterior extent from half a line, or even less, to several inches. I have seen the contraction involve nearly the whole length of the canal.

A very rare obstruction, called the bridle stricture, fig. 581, is occasionally met with. It consists of a small, narrow band stretched across the urethra from one side to the other, and is probably nothing more than a short false passage. Sometimes arranged so as to divide the canal into two parts.

The contracted portion may be soft and elastic, or hard and firm, according to the duration of the disease, and the degree of transformation of the new tissue, upon the presence of which it essentially depends.

Fig. 580.



Indurated Annular Stricture of the Urethra.

Fig. 581.



Bridge Stricture of the Urethra.

Are strictures of the urethra ever impermeable? Much has been said and written upon this subject, especially of late, and it is, therefore, very important that the meaning of the term should be clearly defined, and accurately understood.

As long as a stricture admits of the discharge of urine, it cannot, in the true sense of the term, be considered as impermeable, although it may be impassable by the bougie, sound, or catheter. A stricture that is impermeable to urine is very uncommon; nevertheless, it occasionally occurs, both in the male and female. It has been asserted that there is no stricture that is impermeable to an instrument of some kind or other; that whenever there is room enough for the passage of urine, there is space enough for the introduction of a bougie or probe; and that, when the surgeon fails to accomplish his object, his want of success is attributable rather to his own awkwardness than to the nature of the obstruction.

The fact that this kind of stricture is ignored by certain pathologists, by no means proves its non-existence. The urethra, for example, may be very tortuous, crooked, or zigzag, or there may be a multiplicity of coarctations, so seriously changing the natural relations of the tube as to offer an insurmountable obstacle to the passage of the smallest instrument in the hands of the most adroit and accomplished operator; but I go farther, and assert, upon the testimony of personal experience, that there is a class of cases, the result of ordinary causes, which, while they admit of the flow of urine, slowly and imperfectly it may be, do not permit the introduction of any instrument, however small, into the bladder.

The *symptoms* of stricture, considered generally, are, a diminution of the stream of urine, which is usually spiral, forked, or dribbling, with temporary retention of the last few drops; frequent, slow, and difficult micturition, often preceded, accompanied, or followed by a sense of scalding; a discharge of thin, gleety matter from the urethra; uneasiness about the loins, perineum, and anus; pain in coition; nocturnal emissions; elongation and thickening of the penis; and hardness at the seat of the obstruction, detectable by the finger. During the progress of the disease, the patient is liable to be troubled with swelling of the testicle, chordee, hemorrhoids, hernia, and retention or incontinence of urine. The general health is variously affected, and the slightest exposure, fatigue, intemperance, or irregularity in eating, is sure to be followed by an exacerbation of the local suffering.

Persons affected with stricture are generally excessively irritable, and remarkably susceptible to atmospheric vicissitudes. They are often, so to speak, perfect barometers. The digestive organs are always more or less affected; the alimentary canal is the seat of annoying flatulence; there are frequent acid eructations; the bowels are costive; the tongue is coated, especially in the morning; the head is distressed with dull, aching sensations; the sleep is disturbed by unpleasant dreams; pain and soreness are felt in the sacrolumbar region, perineum, groins, and pelvis; and the urine, scanty and high-colored, is loaded with urates and an inordinate quantity of mucus. If relief is not obtained, the case gradually proceeds from bad to worse;

the strength steadily declines; the flesh wastes; and the sufferer at length expires in a state of complete exhaustion.

Although the above symptoms are, in general, sufficiently denotive of the real nature of the disease, they can, nevertheless, not be regarded as pathognomonic. To establish an unequivocal diagnosis, the urethra must be explored with some instrument. The one which I usually select for the purpose is a common silver catheter, of moderate size, and a little conical at the extremity, which is passed down the tube, first to the obstruction, then into it, and, lastly, if possible, beyond it. In this manner, an idea is easily obtained of the seat and extent of the stricture, as well as of its consistence. When greater accuracy is required, I use a bulbous bougie, represented in fig. 582, carried slowly down to the obstruction, upon reaching which a

Fig. 582.



Bulbous Bougie.

mark is made upon it with the thumb-nail immediately in front of the head of the penis. This will indicate the precise distance of the stricture from the external orifice of the urethra. By slow and cautious manipulations, the bulb of the instrument may be insinuated through the stricture, a second mark indicating the extent of the latter when the shoulder of the bulb meets with resistance during its withdrawal. It will also be found to be highly useful when there is more than one coarctation, as the stem, which is several sizes smaller than the bulb, permits it to move freely in the first, which cannot happen with the ordinary silver catheter. All examinations of this kind should be conducted with the utmost gentleness.

A tolerably correct idea of the nature, seat, and extent of a stricture may sometimes be acquired by the application of the thumb and finger along the under surface of the penis. These remarks are, of course, chiefly applicable to coarctations of the spongy portion of the urethra.

The *pathological effects* of stricture deserve particular study. The affection seldom exists long without giving rise to disease in the adjoining and associated parts. The organs which, besides the urethra, are most liable to suffer, are the prostate gland, bladder, ureters, and kidneys. The testes, penis, seminal vesicles, perineum, and rectum, also, not unfrequently participate in the evils consequent upon the malady.

An occasional, as well as a most serious, effect of stricture is a dilatation of the urethra behind the seat of the obstruction, as represented in fig. 583. This is evidently owing to the manner in which the urine is habitually impelled against the stricture. The canal in front of the obstruction is either normal, diminished, or dilated. When the obstruction is seated in the posterior part of the urethra, the orifices of the prostatic ducts are sometimes so much enlarged as to offer a serious impediment to the passage of conical instruments.

Another consequence of stricture is the development of fistule in the perineum, caused by ulceration or rupture of the mucous membrane behind the seat of the obstruction, and the escape of a small quantity of urine into the subjacent tissues.

The most common lesion of the prostate, in tight, callous, and protracted stricture, is inflammation of the substance of the organ, eventuating occasionally in the development of an abscess, calculous concretions, or great atrophy. Sometimes the gland is converted into a membranous pouch.

The bladder, in confirmed cases, soon becomes hypertrophied, and finally sacculated. There is also not unfrequently a remarkable proneness to the development of urinary calculi, and the lining membrane is in a constant state of inflammation, attended with an inordinate deposit of mucous, and even muco-purulent, fluid.

The most common lesions of the ureters are inflammation of their lining mem-

Fig. 583.



Stricture of the Urethra, with Dilatation of the Tube behind the Obstruction.

brane, suppuration, deposits of lymph, and irregular dilatation of their caliber. Their parietes are often greatly thickened.

The kidneys are variously affected. Inflammation frequently occurs at an early period, and gradually progresses until it ends in serious mischief, if not in total ruin, of the affected structures. The adjoining sketch, fig. 584, strikingly illustrates the effects of stricture of the urethra upon the rest of the urinary organs. The prostate gland is completely destroyed, the mucous membrane of the bladder is removed by ulceration, the ureter is immensely enlarged, and the kidney is converted into a mere shell, filled at the time of the dissection with purulent matter. The drawing is from a specimen in the pathological collection of the New York Hospital.

Fig. 584.



Disease of the Kidney, Bladder, Ureter, and Prostate Gland, from Stricture of the Urethra.

The *causes* of stricture may be conveniently arranged under two heads, the traumatic and the pathological. Of these, the latter are by far the more common. The particular kind of injury is generally a blow, fall, or kick upon the perineum, eventuating in a contusion or laceration of the lining membrane, or of this membrane and the subjacent tissues. A bad stricture occasionally results from the *maladroït* use of a catheter or a bougie, and from the cicatrice left after lithotomy.

Of the pathological causes of stricture by far the most frequent is *gonorrhœa*. It has been supposed that stimulating injections, employed too early in this disease, are capable of producing the affection; this is undoubtedly true, but I am satisfied that the occurrence is much less common than is generally imagined. Judging from my own experience I am convinced that at least forty-nine out of every fifty cases of stricture, not traumatic, are the effect of *gonorrhœa*.

Finally, the disease is occasionally produced by chancre of the urethra. The obstruction, thus induced, is generally situated at the anterior extremity of the canal, at or just behind the external orifice.

The *prognosis* is variable. Stricture, if taken in hand before it has become hard or firm, or while it is still recent, and before it has occasioned any serious lesion of the urinary apparatus, is commonly neither dangerous nor difficult of cure. When, however, it has made considerable progress, offers much resistance to the passage of the urine, and has excited inflammation in the neighboring organs, it may be considered as a very serious affection, liable, if permitted to proceed, to be followed by the worst consequences. It may be stated, as a rule, that a recent stricture is much more easy of cure than an old; a small, than a large; a soft, than a callous; a pathological, than a traumatic. Furthermore, a stricture of the membranous portion of the urethra is usually more difficult to manage than one of the spongy. An obstruction in this situation is also more liable to awaken serious disease of the prostate gland, bladder, ureters, and kidneys.

When a stricture is old and callous it is not only irradicable, that is, hopelessly incurable, but it may gradually so far undermine the general health as to cause death. Sometimes the brain sympathizes with the urinary troubles, and a slow, subacute inflammation, attended with coma, is set up in this organ and in the arachnoid membrane, eventuating at length in fatal serous effusion.

Finally, a hard, tight stricture may be a cause of impotence, by interfering with the ejaculation of the semen, the fluid, instead of passing off in the usual manner, being forced into the bladder, where, mingling with the urine, it is speedily devitalized.

Treatment.—Different methods are employed for effecting the permanent cure of stricture. Of these the most important are dilatation, rupture, cauterization, incision, and external division, each of which has been more or less modified, according to the prejudice, whim, or caprice of practitioners.

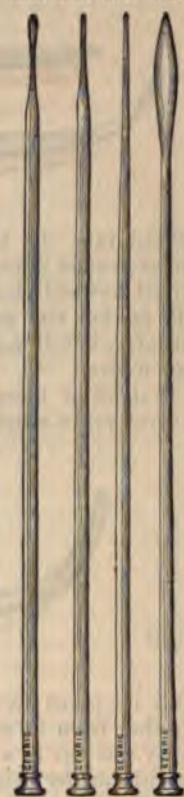
Before resorting to any of these expedients, it is of the first moment to attend to the general health, and to subdue local inflammation. When the way has been thus paved, the particular kind of treatment is to be determined by a careful consideration of the nature of the obstruction.

1. *Dilatation.*—Dilatation is mainly applicable to the milder forms of stricture, and may be performed either gradually, continuously, or suddenly and forcibly, the choice of the procedure depending upon the exigencies of the particular case.

a. In gradual dilatation the object is to proceed as cautiously and gently as possible, so as to avoid all risk of irritation, commencing with an instrument that will readily pass the obstruction, and using afterwards a series of steadily increasing sizes until the cure is perfected. The instruments usually employed for effecting gradual dilatation are the flexible French gum-elastic bougies, the vesical extremities of which may be olive-shaped, conical, or fusiform, as in figs. 585, 586, 587, 588, the first being the one generally preferred, as, from its peculiar conformation, it most readily surmounts the usual impediments to introduction. The length of the instrument varies from a few inches to that of an ordinary catheter. When the obstruction is seated near the anterior orifice of the urethra, a short bougie is generally more convenient than a large one. When the stricture is unusually tight, a solid and resisting instrument is required, and this may be either an ordinary silver catheter, or, what I decidedly prefer, a steel, nickel-plated bougie, furnished with a heavy handle, its vesical extremity, shortly curved, terminating in a somewhat conical point. The great advantage of this instrument is its weight, which, provided it is properly guided, materially facilitates its passage through the obstruction without the risk of making a false passage. Whatever form of bougie be selected, its size is gradually increased, and the introduction is repeated, at first, every second or third day, and subsequently, when the canal has become more tolerant of the operation, once every four-and-twenty hours, the retention at each sitting lasting from five to fifteen minutes. When the dilatation is considerably advanced, the cure will be materially expedited if a small instrument, one that readily enters the stricture, be occasionally inserted, followed immediately by a larger one, carried into the bladder, and almost at once withdrawn. The treatment by gradual dilatation is always tedious, and, in the end, very frequently unsatisfactory, relapses being the rule, and complete cures the exception. Its success is based upon the action of the absorbent vessels, stimulated by the contact of the instrument to the removal of the new tissue, upon the presence of which the obstruction depends. It is, therefore, only applicable to cases of recent origin.

3. When a stricture is so tight as to give rise to considerable difficulty in its penetration, the more especially if it be very sensitive, or of a contractile nature, the treatment may be greatly expedited by substituting for the slow method of gradual dilatation that of *continuous* or permanent dilatation. With this object in view, the pliant, elastic catheter, represented in fig. 506, p. 747, which adapts itself to the natural curves of the urethra, without being productive of the irritation so liable to follow the use of the silver instrument, is passed, if necessary, upon a curved steel stylet, through the obstruction, and retained until it becomes loosened, which usually happens within the first forty-eight hours. It is then replaced by a larger instrument, and the treatment is thus continued until a No. 10 or 12 catheter can easily be introduced, when ordinary dilatation is resorted to. By this method I have frequently succeeded in restoring the urethra to its natural size in a few days, even when the disease was very obstinate.

Fig. Fig. Fig. Fig.
585. 586. 587. 588.

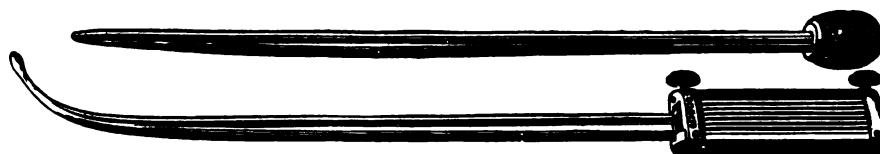


French Flexible Bougies.

When the obstruction is seated some distance in advance of the triangular ligament, the best and safest of all instruments that I have ever employed for the purpose of continuous dilatation is the slippery-elm bougie, made of elm bark, with a slightly conical extremity. Introduced into the urethra, and allowed to remain for some time, it speedily expands under the moisture of the mucous membrane, and thus becomes, as I know from ample personal experience, a most rapid, powerful, and efficient dilator.

γ. In forcible dilatation, long ago practised by myself and others, but at present generally known as the method of Mr. Barnard Holt, of London, the stricture, from the violence employed, is generally torn, the parts giving way at different portions of their extent. Hence this process is generally distinguished as the operation of *rupture*, laceration, or divulsion. The instrument with which it is performed is some one of the improvements upon the original dilator of Perrière, of which the best are those of Holt, Voilemier, and Richardson, to which Van Buren, Bumstead, Gouley, and other surgeons have adapted various contrivances for conducting them safely through narrow coarctations into the bladder. Of these, probably the most perfect is the instrument of Dr. Richardson, of Dublin, sketched at fig. 589. Having been

Fig. 589.

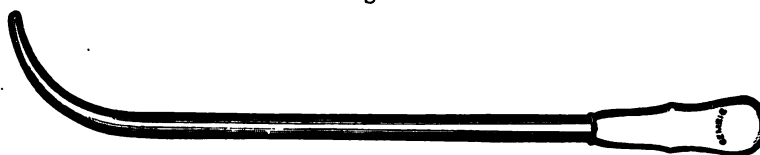


Richardson's Tunnelled-handled Dilator.

passed into the bladder closed, a large, dove-tailed wedge, or plunger, which, with the expanded blades, equals 18 of the American, or 30 of the French scale, is rapidly forced onwards between the blades, when the instrument is rotated so as to separate still farther the rent, and withdrawn. The bladder having been evacuated with a catheter, a full anodyne is administered, and the patient kept in bed for twenty-four hours.

Instead of lacerating the tissues with the ordinary form of dilator, I have for several years employed the heavy, conical, nickel-plated steel bougie, fig. 590, which

Fig. 590.



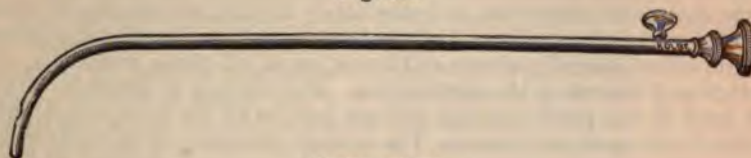
Conical Steel Bougie.

from its point to its shaft represents three sizes of the American scale, the largest running from 16 at the extremity to 18 at the shaft. Six of these bougies are generally put up in a case, and, while they effect the desired object equally as well as the dilator, by being rapidly inserted one after another, they are, according to my experience, far superior to it, especially when the stricture is seated in the membranous portion of the urethra, when, unless very great care is taken, there is always danger, especially in untrained hands, of the dilator slipping out of the natural channel. The operation of rupture with either of these instruments should always be performed under chloroform. It is seldom followed by any hemorrhage, and what bleeding there is usually promptly ceases spontaneously. I have never known it to give rise to any untoward symptoms; it fulfils the same indications as internal urethrotomy; is applicable to all forms of permeable stricture; and is more expeditious than, at the same time that it is as safe as, the apparently simpler procedures. For these reasons I do not hesitate to give it my unqualified approbation.

The after-treatment of rupture is conducted upon general principles. As soon as the immediate effects of the operation have passed off, as they generally do in forty-eight hours, a full-sized steel bougie is inserted, and pressed for a few moments

against the seat of laceration, with a view of stretching the newly formed cicatricial tissue, and thereby preventing its contraction. The introduction of the instrument is subsequently repeated every second, third, or fourth day until the completion of the cure. But, when this has been attained, whether by the gradual or rapid process

Fig. 591.



Porte-caustique.

now described, there is one important point which cannot be too forcibly impressed upon the surgeon's attention, namely, the occasional passage of the bougie during the remainder of the patient's life, at first, and for a long time, once a week, and then regularly once a fortnight. If this precaution be disregarded, relapse will be inevitable, such is the invariable tendency to recontraction in the cicatricial tissues at the seat of the stricture.

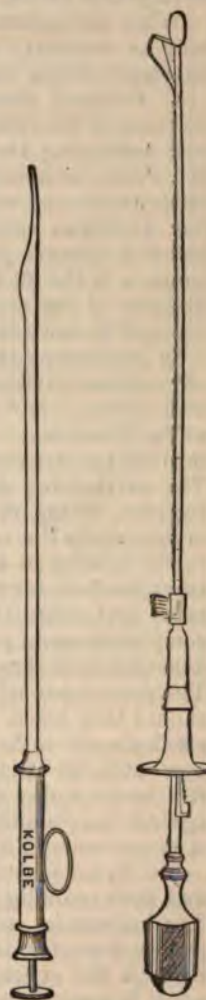
2. *Cauterization.*—This mode of treatment is chiefly adapted to strictures attended with unusual morbid sensibility of the urethra, rendering some of the other procedures difficult and tedious, if not impracticable, on account of the suffering occasioned by it. Employed alone, its action is seldom curative, even in the milder forms of the affection. The operation is performed with the porte-caustique, fig. 591, an instrument which I devised many years ago, and which is far superior, in point of safety, to that of Lallemand, still so much used in this country. It is shaped like a catheter, and is closed at the vesical extremity, near which, at the convex surface, there is an elongated aperture, through which, by means of a cup in the stylet, partially filled with pulverized nitrate of silver, the cauterization is effected by a rotatory movement of the tube, the operation being repeated once every five or six days. The application usually causes some pain and scalding, for the relief of which an anodyne is sometimes required.

The treatment of organic strictures of the urethra by caustic potassa, introduced by Whateley, and so strongly advocated by the late Mr. Robert Wade, of London, has become obsolete. No doubt a good cure was occasionally effected with it, but its employment was hardly safe in the hands of the general practitioner.

3. *Internal Urethrotomy.*—When the stricture is very old, gristly, tight, and intractable, or indisposed to yield to dilatation, or dilatation and cauterization, particularly if it be seated in front of the bulbous portion of the urethra, incision may be used. If, under the same conditions, it be situated within and behind the bulb, rupture is indicated.

The instruments required for this operation vary according to the situation and nature of the stricture. When the coarctation is seated at the orifice of the urethra, or just behind it, a bistoury will answer every purpose; but for the remainder of the tube, the best urethrotome is one composed of a grooved canula, containing a stylet, armed with a little blade, which is made to project at will, and cuts from before backwards. The extremity of the canula, which is intended to lie within the stricture during its division, is of a conical shape, quite narrow, and about three-quarters of an inch long. The instrument which I have for many years been in the habit of employing

Fig. 592. Fig. 593.



Urethrotomes.

in permeable strictures, is exhibited in fig. 591, with the stylet and blade retracted. When the stricture is sufficiently open to admit of the passage of its bulb, one of the best instruments with which I am acquainted is that of Civiale, fig. 593, which cuts from behind forwards, by projecting the blade which lies concealed within the bulbous extremity. Whichever mode be employed, a portion of the sound urethra both before and behind the stricture should be included in the incisions.

When the disease is situated at, or immediately behind, the opening of the urethra, the contracted part is freely divided with a very narrow, probe-pointed bistoury in its entire length, either laterally, above and below, or at all these situations, according to the nature and extent of the obstruction. For cutting a stricture situated between the head of the penis and the bulbous portion of the tube, a straight, lateral bladed stylet is the most convenient. The conical extremity of the instrument being securely engaged in the contracted part, the penis is drawn forward, and the lancet pressed steadily against the resisting surface until it is completely divided at two, three, or more points of its circumference. For a stricture seated farther back the instrument should be curved, and used upon the same principle as the lateral-bladed stylet, but with a greater degree of caution, as this part of the canal is more intricate in its relations and direction. In whatever manner the operation is performed, the moment it is over a gum-elastic catheter is passed into the bladder, and retained for twenty-four hours, the subsequent treatment being the same as that after rupture.

When the stricture is very large, or hard and tortuous, more than one operation may be necessary to effect its division; but, as a rule, it is best to do all that is necessary at one time.

4. *Perineal Section or External Urethrotomy.*—This is nothing less than the division of the stricture by an external incision, extending down through the urethra, and embracing the whole of the constricted surface. The method was devised by Mr. Syme, although it is merely a modification of the button-hole operation—la boutonnière—so well described by Desault, and practiced successfully by many of our American surgeons, as Stevens, Jameson, Physick, Rogers, and Warren, long before it became generalized. The essential difference between the two procedures consists in the fact that in the former a staff is passed into the bladder before the division of the stricture is effected, whereas in the latter the instrument is merely brought in contact with the obstruction.

In performing the operation, which was originally described under the appellation of “external division,” but which is now more generally known under that of the “perineal section,” or “external urethrotomy,” the patient is placed in the same position as in lithotomy. A staff, slightly curved, and sufficiently small to pass readily through the stricture, is then introduced into the bladder, and intrusted to an assistant. The parts being shaved, the nates are brought to the edge of the table, and the surgeon, sitting on a low chair, or resting upon one knee, makes his incisions exactly in the middle line of the perineum, about half an inch above the verge of the anus, the raphé serving as a guide to the instrument. Having divided the superficial structures, he feels for the staff, and, plunging his knife into its groove, he cuts the indurated and contracted tissues through their entire extent, thus laying the surface completely open, precisely as in the operation for anal fistule. The whole wound does not exceed an inch and a half, and occasionally it need not even be so large. The deep fascia of the perineum is not interfered with, lest extravasation of urine should take place. As soon as the stricture has been thoroughly opened, a medium-sized elastic catheter is carried into the bladder, where it is retained by suitable apparatus for at least forty-eight hours, when it is removed, to be used afterwards a few hours a day until the wound is healed. The outcry that has been uttered against the retention of the catheter after this operation is, in great degree, baseless. A double-curved Syme instrument is generally perfectly harmless.

Mr. Syme constructed a staff for the purpose of simplifying the whole procedure, and thus enabling the surgeon to make his incisions with greater ease and precision. The instrument, represented in fig. 594, on a scale exactly half the length, but of its proper diameter, is very slender at the vesical extremity, and is thus readily passed through the stricture into the bladder, while the other portion, which is as large as a No. 8 catheter, stops abruptly in front of the obstruction, thereby indicating its anterior limit, and the point, consequently, at which the incision should terminate in this situation.

The perineal section has met with much opposition, founded, in great measure, upon ignorance and prejudice. That it has been much abused is certain; but when the cases are well selected, and the operation is properly performed, the result is generally all that could be desired. It should be reserved for traumatic strictures, and for cases complicated with great induration and fistules, non-dilatable strictures yielding to the safer method of rupture. Relapse will be most likely to follow when there has been neglect in the after-treatment, and in old, worn-out, chronic cases, with a riddled perineum and a diseased condition of the urinary organs. I have myself performed the operation between twenty-five and thirty times, without, in any instance, any bad effects. Of 108 cases in the hands of Mr. Syme, up to 1863, 2 only had ended fatally. Of 345 operations, analyzed by Dr. Gouley, as having been performed by American surgeons, nearly 100 without a conductor, there was a mortality of 41, or about 12 per cent., death in a great majority of them having been caused by pyemia and advanced disease of the bladder and kidneys. Of 219 cases with a conductor, collected by Sir Henry Thompson, the mortality was $6\frac{1}{2}$ per cent.

In the button-hole operation, as the conductor is not passed into the bladder but only down to the seat of the obstruction, the amount of skill required is much greater than in the ordinary procedure. Indeed, it should never be undertaken unless the surgeon is thoroughly acquainted with the anatomy of the parts, is perfectly self-possessed, and knows how to use the knife. A number of cases have been reported in which death occurred from hemorrhage, shock, pyemia, erysipelas, or urinary infiltration. Neither this operation nor the more ordinary perineal section should ever, if possible, be performed without due preparation of the parts and system, by rest in the recumbent posture, the application of leeches, the use of anodyne suppositories, and a proper regulation of the diet, with the daily employment of the warm bath.

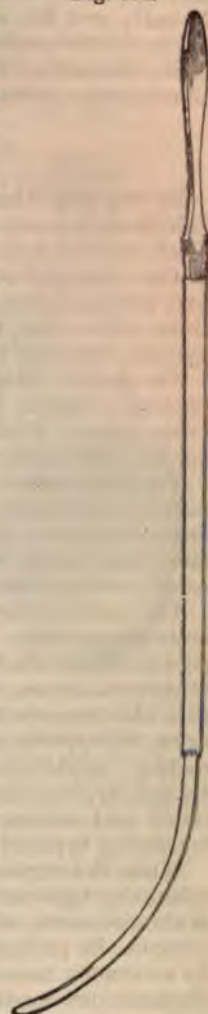
Injurious Effects of Operations Upon the Urethra.—The different methods of treatment now described are all liable, however carefully or judiciously conducted, to be followed by very serious and even fatal consequences. It is well known that patients, especially such as are very nervous and irritable, occasionally suffer most violently from the most trifling operations upon the urinary organs.

In another class of cases, a still more serious effect is occasionally witnessed, especially after operations upon the urethra and the neck of the bladder. I allude to the occurrence of pyemia, or the formation of matter in the joints, muscles, veins, cellular tissue, and other structures. The disease sometimes resembles an attack of ordinary intermittent fever. Occasionally, again, it closely simulates gout or rheumatism. In whatever manner it makes its appearance, the case soon assumes a most threatening character.

In regard to the unpleasant nervous symptoms which occasionally succeed these operations, much may be done in the way of prevention by the use of chloroform; but, when they are unavoidable, no time should be lost in moderating and relieving them. From half a grain to a grain of morphia, according to the age and condition of the patient, is given at a single dose, along with a liberal quantity of brandy, or brandy and spirit of camphor. The extremities, and even the spine, are covered with sinapisms, and cloths, wrung out of hot water and laudanum, are steadily maintained upon the genitals, perineum, and hypogastrium. If undue reaction takes place, abatement may be sought with leeches, morphia, the neutral mixture, and other suitable means.

Arthritic symptoms, and the formation of matter in the cellular tissue, joints, muscles, and viscera, must be relieved by leeches, blisters, iodine, and warm fomentations, medicated with laudanum and acetate of lead, and by the internal use of calomel and opium, aided, if necessary, by suitable stimulants, as carbonate of am-

Fig. 594.



Syme's Staff.

monia, quinine, iron, wine, brandy, and porter. Superficial abscesses must be opened by early and free incisions, both to moderate pain and to prevent further contamination of the system. Unfortunately, however, no mode of treatment, whatever may be its character, can avail much under such circumstances, death being the lot of almost every patient thus affected.

INFILTRATION OF URINE.

By the term "infiltration," as applied to the urine, is understood an escape of this fluid from the urinary passages, and its diffusion through the surrounding tissues. There are two forms of the affection, the vesical and urethral, both most unfortunate, as the urine, putrid and poisonous from long confinement, lights up severe inflammatory action, rapidly terminating in gangrene of the affected structures. The patient sinks into a low, typhoid condition, attended with hiccup and muttering delirium, speedily followed by exhaustion and death.

The *vesical* form of the lesion may be produced by rupture of the bladder from external violence, overdistention from urine, or perforative ulceration of the coats of the organ. Infiltration is occasionally met with after lithotomy, especially in the hands of ignorant operators, and is one of the chief sources of danger.

The prognosis is generally very unfavorable, the treatment being in the highest degree unsatisfactory. When the urine has a tendency to advance towards the perineum, the great remedy obviously consists in making early, free, and dependent incisions, to give vent to pent-up fluids, and in sustaining the system by the timely use of tonics, stimulants, and opiates.

The *urethral* form of infiltration is more common than the vesical, but generally more manageable. If the rupture occur in the commencement of the membranous portion of the urethra, behind the triangular ligament, the case may remain obscure for several hours, or even days. The most reliable symptoms of the accident are, pain and deep-seated throbbing; difficulty, if not utter impossibility, of voiding the urine, with, perhaps, a frequent desire to do so; a sense of fullness in the anus and rectum; tenderness in the hypogastrium; and excessive constitutional disturbance. By and by, the urine makes an effort to approach the surface, its progress being preceded and accompanied by heat, pain, redness, and swelling, and by a rapidly increasing typhoid state of the system.

When the rupture occurs in the portion of the urethra which lies in front of the triangular ligament, between it and the bulb, the urine escapes into the cellular tissue of the perineum, and proceeds forwards and upwards underneath the dartos into the scrotum, its passage being marked by a red, erysipelatous blush of the surface, and by enormous tumefaction, soon succeeded by black, gangrenous spots, and an emphysematous condition of the areolar tissue. The fluid sometimes extends over the entire penis, the upper part of the thigh, the hypogastric region, and over the side of the chest. In a case recorded by Boyer, it affected the loins and back as high up as the scapula.

The symptoms of infiltration of urine are occasionally most painfully simulated by erysipelas of the scrotum and penis, especially in persons of intemperate habits and dilapidated constitution. The disease, which generally advances very rapidly, is attended with enormous swelling and great local suffering, from the effusion of serum and plasma. The skin is of a reddish, glossy hue, and freely pits on pressure. The patient is pale, feeble, and depressed; the pulse is small, quick, and tremulous; the respiration is frequent; micturition is difficult; and, if relief be not promptly afforded, gangrene ensues. The diagnosis is based on the history of the case, the absence of swelling of the perineum, and the facility with which the catheter is passed.

The prognosis is seldom flattering, although apparently the most desperate cases occasionally recover. The first, and, in fact, almost the only thing to be done, in the early stage of the affection, is to make large and dependent incisions, to afford vent to the pent-up and irritating fluids. A catheter should then be introduced into the bladder, and allowed to remain there during the cure. The best local applications, after the parts have been properly divided, are warm fomentations with acetate of lead and opium, hops, or poppy heads. When the sloughing process has fairly begun, the fomentations may be advantageously superseded by emollient poultices, with the addition of yeast, port wine, nitric acid, or chlorinated soda.

ABSCESS.

Abscesses, to which the term urinary is usually applied, are liable to form in the connective tissue around the urethra, fig. 595, leading, if improperly managed, to fistules and other mischief. Their ordinary site is the perineum, between the bulb of the urethra and the anus. A very common situation also is the upper part of the perineum, just behind the junction of the cavernous bodies of the penis, and, consequently, at the inferior portion of the scrotum. The next most frequent point is the scrotum itself, and, lastly, the under surface of the penis. Urethral abscesses are generally small and circumscribed.

The exciting causes are various. The most common, perhaps, is the existence of a tight, organic stricture of the urethra, attended with attenuation and dilatation of the tube immediately posterior to it. During a violent effort at micturition, the tube gives way behind the seat of the obstruction, sending the urine abroad into the connective tissues. A few drops thus effused are often sufficient to cause an immense abscess, accompanied by great suffering, both local and constitutional.

The existence of the disease is, in general, easily determined. The perineum is of a reddish, erysipelatous appearance, swollen, painful, and tender on pressure; progression is difficult; trouble is experienced in micturition, especially if the case is already somewhat advanced; and there is usually more or less fever, attended, when there has been effusion of urine, with a tendency to delirium. Fluctuation is best detected by inserting one finger into the rectum, and placing the other over the tumor in the perineum.

The treatment is sufficiently simple. The antiphlogistic regimen, rest, recumbency, leeching, and fomentations, will limit the morbid action; while a free and timely external incision will prevent the diffusion of matter and urine. When the sac has been emptied, and the accompanying inflammation has, in great measure, disappeared, a catheter should be retained in the bladder, to prevent the escape of its contents by the abnormal orifices, the edges of which are to be touched, from time to time, with nitrate of silver, to promote cicatrization.

Fig. 595.



Urethral Abscess, the Tube being laid open; a Stricture at the commencement of the Bulbous Portion; and False Passages, one of which leads into an Abscess that surrounds the Membranous Portion.

URETHRAL FISTULE.

The most common site of urethral fistule, 596, is that portion of the tube which corresponds with the perineum and the scrotum; the disease sometimes exists farther back, and, on the other hand, cases occur in which it is found near the anterior orifice. The abnormal channel, whether single or multiple, long or short, straight or devious, is originally merely a sinus, or tubular ulcer, which is soon covered by granulations, and ultimately lined by an adventitious membrane.

The immediate cause of this affection is the destruction of the mucous membrane, produced by ulceration, abscess, gangrene, or laceration, and followed by an escape of urine into the connecting cellular tissue. Here, acting as a powerful irritant, the fluid speedily excites inflammation, which soon terminates in suppuration, if not in the death of the affected parts. When the matter is evacuated, or the slough detached, the urine

Fig. 596.



Urinary Fistules.

issues at the accidental opening, which now constitutes, in the true sense of the term, a fistule.

The efficient causes are various. The most frequent, undoubtedly, is stricture, attended with dilatation of the tube behind the seat of obstruction; but it may also result from ill-managed attempts to pass instruments, the protracted sojourn of catheters and bougies, gonorrhoea, retention of urine, external violence, and the operation of lithotomy.

The diagnosis is usually easy. An opening exists in some portion or other of the urethra, giving vent to urine either in drops, in jets, or in a continuous stream synchronous with the act of micturition. A probe of small size, introduced into the external orifice, readily enters the urethra, provided the abnormal passage is not very narrow, oblique, angular, or sinuous.

The *treatment*, although obvious enough, is not always easy. The first thing to be done is to seek for, and, if possible, to get rid of, the exciting cause. In most cases this will be found to be a stricture, probably of long standing, upon the removal of which the abnormal track ordinarily closes of its own accord. The best plan, after the obstruction has been relieved, is to use a soft catheter, rather over than under the usual size, to be permanently retained, unless it should prove to be a source of decided suffering. Conducted upon this principle, the treatment rarely fails in the more mild and uncomplicated forms of the malady. It sometimes, however, happens, after all obstruction in the urethra has been removed, that the fistule manifests no disposition to heal, but remains pervious to the urine. The occurrence may be owing to various circumstances. Very often it depends upon a callous condition of the parts, preventing the edges of the sinus from coming in contact. When this is the case, the object should be to destroy the secreting surface, and to promote the granulating process by stimulants and escharotics, especially nitrate of silver. In rebellious cases a heated wire, or a probe dipped in acid nitrate of mercury, may be inserted into the passage.

When the fistule is obstinate and protracted; when its internal orifice is uncommonly large, or when there are several openings of this kind; or, finally, when it depends upon an old stricture, so firm, narrow, and extensive that it cannot be destroyed in the ordinary manner, the only course left is to lay the parts open by an external incision, and to heal them over a catheter.

When the fistule involves the spongy portion of the urethra, and has been caused by chancre, or external injury, attended with loss of substance, the suture may be necessary, and the one usually selected is the twisted, made with short, slender needles, placed hardly a line and a half apart. The principal objection to the use

Fig. 597.

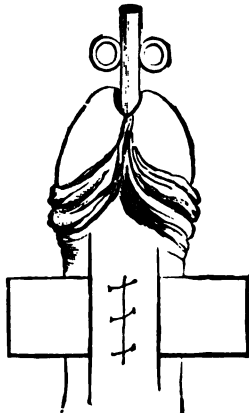


Fig. 598.



Urethroplasty.

of the suture, in any form, is its liability to tear itself out before the completion of the adhesive process, from the occurrence of chordee. The best preventives of such

an accident are anodyne enemata, suppositories of opium and camphor, and the application of pounded ice to the perineum. Excision of the fistule has sometimes been practised beneficially, and there are few cases in which the edges of the track may not be pared with advantage.

When the fistule is attended with considerable loss of substance, *urethroplasty* may be necessary, the requisite amount of material being borrowed from the neighborhood and carefully adapted to the edges of the opening, previously refreshed with the knife. The operation, however, generally signally fails, whatever care may be taken in its execution, owing to the difficulty of preventing the contact of the urine. In order to guard against this, it has been proposed, after the edges of the fistule have been properly pared, to dissect up a large cutaneous flap on each side, and to unite them by suture along the middle line, over a piece of India-rubber, as exhibited in fig. 597. Or, instead of this, the integument may be dissected up subcutaneously, as in fig. 598. Whatever procedure be adopted, a medium-sized catheter should be retained in the bladder until the adhesion is completed, the urine being voided at stated periods, while gentle pressure is made below the seat of the fistule, in order to prevent the fluid from passing by the side of the instrument.

The difficulty of effecting adhesion of the transplanted integument in this operation is generally so great that it seems to me it would be well, until this is accomplished, to afford the urine an opportunity of passing off by the perineum, a small opening sufficing for this purpose.

FALSE PASSAGES.

A false passage is an artificial canal communicating with the urethra, generally as a consequence of the injudicious use of instruments, and is most common in the membranous and prostatic portions of the tube. The lesion is well seen in fig. 599, from a preparation in my cabinet.

Fig. 599.



Stricture of the Urethra, with False Passage; Enlargement of the Prostate Gland, and Hypertrophy of the Bladder.

The artificial route is commonly situated upon the floor of the urethra, chiefly because when an instrument is attempted to be introduced into the bladder, its point is almost always pressed in this direction, which also presents the greatest number of natural obstacles to its easy passage. The new channel, which is usually single, varies in length from a few lines to several inches, and may occur either as a cul-de-sac or as a distinct canal, the distal extremity opening into the urethra, or, perhaps, as occasionally happens, into the bladder, or even into the rectum.

When the false passage consists merely of a cul-de-sac, little, if any, harm will be likely to arise; but it is different when it opens into the bladder, or even when it runs up close to it, for then it may be followed by infiltration of urine, abscess, and even gangrene. When it extends into the rectum, or the rectum and bladder, a permanent fistule may be the consequence.

The formation of false passages is seldom indicated by any reliable symptoms. The most common are hemorrhage, pain, and a feeling of laceration; but these, upon being carefully scrutinized, will be found to be of no value whatever as diagnostics. How, then, is the existence of the lesion to be determined? Is any confidence to be placed in the observation of the surgeon? The only circumstances worthy of notice, as far as he is concerned, are, first, a peculiar grating sensation communicated to his hand while engaged in operating upon the urethra; secondly,

a sudden slipping of the instrument from its position, or a feeling as if something had given way; thirdly, a deviation of the instrument from the normal direction of the canal; and, lastly, the occurrence of unusual bleeding.

The treatment is quite simple. Hemorrhage must be arrested, pain allayed, and further irritation by the use of instruments prevented. Rest and recumbency, light diet, purgatives, antimonials, leeches, fomentations, and the warm hip-bath will generally put a speedy stop to the local inflammation. Urinary infiltration is a rare occurrence, owing to the fact that the water, flowing in a direction opposite to that of the artificial opening, is unable to insinuate itself into it.

HETEROLOGOUS FORMATIONS.

The urethra, like the urinary bladder, is liable to the heterologous formations, as epithelioma, encephaloid, and tubercle. These affections, however, are extremely rare, especially as independent deposits, and their occurrence is interesting rather in a pathological than in a practical point of view. Of colloid and melanosis of this tube, we are entirely ignorant.

There are no symptoms by which, in either sex, carcinoma of the urethra, in its earlier stages, can be distinguished from other affections. All treatment, except with a view to palliation, is futile. Should retention of urine occur, the morbid growth must be perforated with the catheter, or, when this is impracticable, the urethra must be laid open behind the tumor.

SECT. IV.—DISEASES AND INJURIES OF THE PROSTATE GLAND.

The prostate gland, from the peculiarity of its situation, and its intimate connection with the bladder, the urethra, and the seminal vesicles, is constantly exposed to inconvenience and hardship, rendering it liable to various diseases; but, until the age of puberty, it has merely a rudimentary existence, and is, therefore, seldom affected in any way. After its functional activity, however, is fully awakened, it becomes more liable to disorder, and this tendency may be said steadily to increase as we advance in life.

The affections of the prostate may be conveniently arranged under the following heads: 1. Inflammation. 2. Suppuration and abscess. 3. Ulceration. 4. Hypertrophy. 5. Prostatorrhœa. 6. Tumors. 7. Tuberculosis. 8. Hemorrhage. 9. Calculi. 10. Sacciform disease and fistule.

1. *Acute Prostatitis*.—Acute inflammation of the prostate seldom exists as a primary affection, except when it is produced by direct injury. Idiopathically considered, it is most frequently met with in middle life, when the genital organs are in their full vigor, and in active sympathy with the rest of the system. The most common exciting causes of acute prostatitis are gonorrhœa, stricture of the urethra, venereal excesses, horseback exercise, external injury, and suppression of the cutaneous perspiration. Gleet is occasionally followed by acute prostatitis; and cases occur in which it is evidently associated with, if not directly dependent upon, a gouty or rheumatic diathesis.

The characteristic symptoms are deep-seated, burning, and throbbing pain, gradually increasing difficulty in micturition, excessive scalding of the urethra as the urine flows over its surface, a feeling of weight and stuffing in the rectum, constant tenesmus and desire to relieve the bladder and bowels, and a flattened form of the feces. If the finger be inserted into the rectum, the gland may be distinctly felt as a solid, painful tumor, sometimes almost sufficiently large to close the tube and seriously impede defecation. The attempt to introduce a catheter into the bladder will be found to be exceedingly difficult, if not impracticable, unless the surgeon possesses more than ordinary skill in the management of the instrument. The local symptoms are generally accompanied by well-marked constitutional disturbance.

Although this disease is seldom dangerous to life, or disposed to run into suppuration, yet, in view of the great suffering which it induces, the treatment should always be very prompt and decisive. Active depletion by the lancet, and by leeches to the perineum and anus, is always indicated, especially if the patient is robust, and should be practised without delay. If the bowels are costive, the venesection is immediately followed by a brisk cathartic, consisting of castor oil, or calomel and jalap, assisted, if necessary, by enemata. Fever is combated by antimonial and

saline preparations, in union with morphia and aconite, to allay pain and depress the heart's action. Relaxation of the skin is promoted by hot steam, conveyed to the body by means of a tube connected with the spout of a tea-kettle. The genital organs, hypogastrium, and perineum should be enveloped in flannel cloths, wrung out of hot water and laudanum; and the pain and straining, which so commonly attend the disease, should be promptly subdued by a full anodyne enema, opiate suppository, or hypodermic injection of morphia. Great relief sometimes follows the use of the hot sitz-bath.

The condition of the bladder is early attended to, retention of urine being relieved by the catheter, handled with the greatest gentleness. Absolute recumbency is indispensable throughout the whole treatment; the diet must be of the blandest character, and drink of every description is abstained from, in order to secure repose to the inflamed parts.

2. *Abscess*.—Acute inflammation of the prostate occasionally terminates in abscess. When this event is about to take place, there is an increase of all the previous symptoms, both local and constitutional. The pain is exceedingly violent, and is speedily followed by complete retention of urine. Severe rigors, alternating with flushes of heat, are present, and the patient soon becomes delirious. An examination by the rectum often detects fluctuation. When the abscess tends towards the perineum, its advent is always preceded by marked swelling, an erysipelatous blush of the surface, and an oedematous condition of the subcutaneous cellular tissue.

The annexed cut, fig. 600, from a preparation in my cabinet, affords a good illustration of an abscess of the prostate, as it occurred in an elderly man, who died from the effects of the disease, ten days after the commencement of the first symptoms. The pus was of a thick, cream-like consistence, and of a yellowish color, its quantity being a little over a teaspoonful. The inflammation had deeply involved the neck of the bladder.



Abscess of the Prostate.

Abscess of the prostate is generally a dangerous affection. When recovery occurs, the patient may be troubled with a fistulous communication with the rectum, urethra, perineum, or bladder.

In the treatment, the leading indications are, to limit the suppuration, and to afford a speedy outlet to the effused fluid. To fulfil the first, prompt recourse must be had to depletion, provided this has not already been carried sufficiently far, to antimonials, diaphoretics, anodynes, and emollient applications. Blood may be taken by leeches from the perineum and hypogastrium.

The second indication is fulfilled by an early artificial opening. If the abscess points towards the perineum, an incision should be made in the most prominent part of the swelling, with a long, straight, narrow-pointed bistoury, care being taken, on the one hand, to avoid the bowel, and, on the other, the bladder.

When the abscess points towards the rectum, it may readily be reached with a long, curved trocar. For some days after the operation the lower bowel should be kept as quiet as possible.

When the abscess bulges inwards towards the urethra and the neck of the bladder, it may be punctured with a common silver catheter; or, instead of this, a sound with a conical beak and a small curve may be used. When, notwithstanding the abscess is not completely matured, further delay would be improper, the operation may be executed with a lanceted stylet. The urine should be frequently drawn off with a gum-elastic catheter, or, what is better, if it can be tolerated, the instrument should be permanently retained in order to allow the water to flow off as fast as it reaches the bladder, and thus prevent its accumulation in the cavity of the abscess. The point of the catheter, as it is urged along, must be kept in close contact with the roof of the urethra, especially as it passes under the arch of the pubes.

3. *Ulceration*.—Ulceration of the prostate is of infrequent occurrence and of difficult recognition. It is induced by various causes, of which the principal are wounds, contusions, lacerations, and the presence of calculous concretions in the substance of the organ.

The symptoms are such as indicate the existence of chronic disease of this organ

and of the neck of the bladder. Perhaps the most reliable circumstances, in a diagnostic point of view, are, the absence of vesical calculi, long-continued suffering, as a sense of weight, aching, and throbbing at the neck of the bladder, a constant secretion of thick, glairy mucus, a frequent desire to micturate, and an occasional discharge of blood, with excessive burning during the accumulation of the urine.

The treatment is altogether unsatisfactory and empirical. Attention must be paid to the general health; the patient should avoid exercise and the erect posture; the bladder should be daily washed out with tepid water, either simple or medicated; and the affected surfaces should be lightly touched twice a week with a solution of nitrate of silver, in the proportion of about ten grains to the ounce of water, applied with a piece of soft sponge, projected from a silver canula. The best internal remedies are, balsam of copaiba, cubebs, and spirit of turpentine, largely diluted with demulcent fluids. Anodynes must be freely used both by the mouth and by the rectum.

4. *Hypertrophy*.—Hypertrophy of the prostate is an augmentation of volume of this organ, produced by increased nutrition. There are several forms of the complaint, of which the most common is that to which the term *senile* has been applied, as it is a frequent accompaniment of old age.

Hypertrophy may occur in any part of the organ. Most commonly it involves the entire gland, although not uniformly. Occasionally it is almost exclusively confined to the third lobe, even, perhaps, when the enlargement is so great as to cause retention of urine, and, ultimately, the patient's death. The affection exists in various degrees, from the slightest increase of the natural volume of the prostate to the dimensions of a pullet's egg, a walnut, or a medium-sized orange. In rare cases, indeed, it may even exceed the latter dimensions. The greatest



Hypertrophy of Both Lobes of the Prostate.

increase of volume usually occurs in the long axis of the organ, in consequence, no doubt, of a want of resistance in this direction. The annexed drawing, fig. 601, from a specimen in the collection of the late Dr. Mott, affords a good illustration of what may be called symmetrical hypertrophy of both lobes of the prostate. Fig. 602, from one of my preparations, exhibits great enlargement of the gland in its antero-posterior diameter, with a mammillated appearance at its posterior extremity, seemingly dependent upon an irregular condition of the middle lobe.

When one lateral lobe is more enlarged than the other, the more bulky one frequently encroaches upon the smaller, and thus produces a lateral curvature in the neck of the bladder and the commencement of the urethra.

Hypertrophy of the middle lobe most generally presents itself as a mammillary process, more or less vertical in its direction, and varying in size from that of the female nipple to that of a small almond, as in fig. 603. The free surface is usually smooth, rounded, and much broader than the adherent, which is often very narrow, as if it were inserted between the lateral masses by a distinct pedicle. Its position is commonly median, and, as it always projects into the bladder, its tendency, especially when it is very large, is to raise and elongate the prostatic portion of the urethra. Cases occur in which there are as many as three or even four of these bodies, as in fig. 602, of varying size and shape. When the number is considerable, they sometimes partially invade the orifice of the urethra, and necessarily produce a corresponding degree of mechanical obstruction. In a specimen in my cabinet, both lateral lobes are much enlarged, while the middle is represented by three separate lobules, one central and the other lateral. Finally, the middle lobe is occasionally formed by a projection, apparently, of one of the lateral masses, as if it were a mere superaddition to the normal structure. In chronic hypertrophy, which is very common in elderly subjects, and which often exists without any material increase of

bulk in the rest of the gland, the growth extends inwards towards the middle line, and usually encroaches more or less seriously upon the corresponding portion of the urethra.

Fig. 602.



General Hypertrophy of the Prostate.

Fig. 603.



Hypertrophy of the Prostate, with Mamillary Enlargement of the Middle Lobe.

The consistence of a hypertrophied prostate is liable to considerable diversity, and occurs under two very opposite forms, the hard and the soft. In the first, which is the more frequent, the induration varies from the slightest increase of the natural consistence to the firmness of dense, fibrous tissue. Interspersed through its substance are numerous hypertrophied follicles. In the soft variety, the enlargement proceeds in a more uniform manner, and generally attains a greater magnitude than in the hard. The affected tissues are more or less elastic, and yield readily under the pressure of the finger. The follicles are larger and more conspicuous than in the first variety.

Hypertrophy always arises under the influence of causes acting in a slow and permanent manner. Whatever, therefore, has a tendency to keep up habitual engorgement in the organ may be considered as being capable of producing it, augmented action necessarily occasioning an augmented afflux of blood, and a corresponding increase of nutrition. Amongst the more frequently enumerated causes of the affection are excessive venery, stricture of the urethra, disease of the bladder, horseback exercise, gonorrhœa, and stimulating diuretics. That these causes are all capable of inducing the disease, is no doubt true; but, on the other hand, it is equally certain that they are often accused when they are entirely innocent. Some of the very worst cases of hypertrophy of the prostate occur in old men who have led the chastest life, who have not rode on horseback, and who have never had any disease whatever of the urethra.

The senile form of the affection rarely occurs, at least not in any considerable degree, before the fiftieth year; slight evidences of it are occasionally met with at forty-five, and, indeed, even at forty, but this is exceedingly uncommon. Hypertrophy, not the result of old age, may arise at any period of life, under the influence of inflammatory excitement and vascular engorgement.

The influence of old age in the production of hypertrophy of this organ has been greatly overrated, as will appear from the subjoined table of 312 examinations made at my request by my friend, Dr. John W. Lodge, in 1859, while resident physician at the Philadelphia Hospital.

Number.	Age.	Normal.	Hypertrophied.	Atrophied.
23	40 to 50	21	2	...
94	50 to 60	73	18	3
113	60 to 70	84	27	2
64	70 to 80	53	11	...
15	80 to 90	12	3	...
3	90 to 100	3
Total .	312	246	61	5

In 100 dissections of the prostate after the age of sixty, by Dr. J. C. Messer, hypertrophy was found in 35 per cent., atrophy in 20 per cent., and normality in 45 per cent. These results essentially coincide with those of Sir Henry Thompson, who attests that the gland is hypertrophied in 35 per cent. after the fiftieth year. Professor Dittel, of Vienna, found hypertrophy of the prostate in 18 cases, and atrophy in 36 in the bodies of 115 individuals, the youngest of whom was 52 and the oldest 100 years of age.

The complaint seems to depend essentially upon hyperplasia of the unstriped muscular and fibrous elements which constitute the chief bulk of the prostate, and which, during the progress of age, are liable to new growth similar to that so often witnessed in the uterus of elderly females. The glandular structure, which forms hardly one-third of the volume of the organ, of course participates in the morbid action, as is shown by the dilatation and epithelial proliferation of its acini, without, however, any development of new glands. Hence, hypertrophy of the prostate cannot be regarded as an adenoma, in the true sense of the term. In the denser forms of the affection, on the contrary, there is actual atrophy, and even complete disappearance, of the glandular substance, the organ being in the condition either of a myoma or a myomatous fibroma.

Irritation of the neck of the bladder, and a frequent desire to pass the urine, are the *symptoms* which generally first attract the attention of the patient. By degrees, the distress at the neck of the bladder becomes more constant, as well as more severe, and there is not only a frequent desire to void the urine, but great difficulty in starting it. Slight pain is felt along the urethra, accompanied by a burning, smarting, or scalding sensation in the head of the penis, and a copious discharge of prostatic fluid. The rectum never feels entirely empty, even after the most thorough purgation, but as if it contained a lump or ball, and the feces are often passed in a flattened form. At night the patient is occasionally disturbed by an involuntary discharge of seminal fluid. As the disease advances, the symptoms become more aggravated, although they are still essentially of the same character. The general health, until now, perhaps, tolerably good, slowly declines.

The urine, at first perfectly clear, and, apparently, natural, is gradually changed in its properties, and sometimes even in its quantity. It is generally thick, fetid, acrid, and highly alkaline, depositing, on standing, a great abundance of thick, ropy mucus, often streaked with phosphatic matter. The fluid is soon decomposed, if, indeed, it is not so before it is voided, and then always exhales a strong ammoniacal odor. Gradually micturition becomes more and more difficult, and, at last, after months and, perhaps, years of the most cruel suffering, the urine is either retained, or is obliged to be drawn off constantly with the catheter.

The *diagnosis* of hypertrophy of the prostate is generally not difficult. The disease, as previously intimated, is almost peculiar to advanced life. Hence, when a person who has attained the fiftieth, fifty-fifth, or sixtieth year, is laboring under the above train of symptoms, the presumption is strong that the case is one of chronic enlargement of this body, and nothing else. The affections with which it is most liable to be confounded are, stricture of the urethra, urinary calculi, catarrh of the bladder, and stricture of the rectum. All, however, that is necessary in any case to determine the diagnosis is a digital examination of the gut. For this purpose, the left index-finger, gently inserted into the tube, is moved about in different directions, first upwards along the middle line, and then successively towards each side, noting, as it proceeds, the impression made upon it by the affected gland. In general, it will be found, as before stated, to be larger on one side than the other, and to feel like a hard, solid body, the surface of which is either smooth and uniform, or irregularly knobby.

The existence of centric hypertrophy may be suspected when there is constant difficulty of micturition, without any appreciable disease of the urethra and bladder, as stricture of the former, and atony, paralysis, hypertrophy, calculi, or morbid growths of the latter. On introducing an instrument the point will probably be arrested by the lateral curvature of the gland, or by the centric projection of a portion of its substance, in the form of a tubercle, of varying size and shape. Such a condition of the organ may, as previously stated, be present, and yet the main body of the gland be entirely natural.

The *effects* of hypertrophy of this gland upon other parts of the urinary apparatus are frequently very distressing. The organ which is most liable to suffer is

the bladder, the muscular coat of which becomes greatly thickened and fasciculated from the constant obstacle to the evacuation of the urine. For the same reason, the mucous membrane is always chronically inflamed, and sometimes mammillated, ulcerated, or even sacculated. Another effect is the occasional formation of urinary calculi.

The urethra, too, often undergoes important changes. In general, they are exclusively limited to the prostatic portion of the tube, which, in the more aggravated forms of the hypertrophy, is nearly always remarkably elongated and much diminished in size, causing thus serious mechanical obstruction to micturition and the introduction of the catheter. In enlargement of the middle lobe, the urethra is dragged up behind the pubic arch. Lateral curvature of the canal is occasionally met with, and is generally dependent upon an unequal outgrowth of the inner edges of the lateral lobes. In great centric development of the gland, the corresponding portion of the urethra is sometimes almost completely occluded.

The ureters are seldom entirely sound. The most common lesions are shortening and dilatation, or alternate dilatation and contraction, with irregular thickening or attenuation of their walls. The kidneys also generally suffer, mostly from inflammation, attended with change of structure, size, and shape. Sometimes they undergo cystic degeneration. The seminal vesicles and testicles are occasionally involved, and there are few cases of great hypertrophy of this organ in which the patient is free from disease of the anus and rectum, especially prolapse and hemorrhoids, evidently caused by the frequent and excessive straining consequent upon the difficulty experienced in micturition.

The treatment of hypertrophy of this gland seldom fulfils the expectations of the surgeon. On the contrary, chagrin and disappointment nearly always attend his efforts, however judiciously directed, especially in the more aggravated forms of the affection. The most trustworthy remedies are rest in the recumbent posture, the abstraction of blood from the perineum by leeches, anodyne suppositories, frequent clearance of the bladder with the catheter, a soluble condition of the bowels, the avoidance of sexual intercourse and horseback exercise, and a properly regulated diet, nutritious and concentrated but non-stimulant. When the hypertrophy depends upon inflammatory new formations, benefit will accrue from the use of small doses of calomel repeated several times in the four-and-twenty hours, either alone or alternated with hydrochlorate of ammonia. When the exciting cause is manifestly of a syphilitic nature, the most suitable article will be iodide of potassium in combination with bichloride of mercury. Little, if any, benefit is to be anticipated from counter-irritation, in any form, not even from vesication of the perineum with cantharidal collodion. Cauterization of the prostatic portion of the urethra is sometimes advantageous, by stimulating the absorbent vessels, and thus inducing them to remove inflammatory deposits. Scarification has occasionally been practised, but seldom, if ever, with any ulterior benefit. Some practitioners have indulged in high laudations of the good effects of suppositories of iodide of potassium, and of the daily use of a bougie anointed with weak mercurial ointment. I have myself however, never derived any relief from their employment. Injections of the bladder, as advised under the head of vesical catarrh, frequently affords great comfort, by dislodging the thick, ropy, and offensive mucus which so often collects in the bas-fond of this organ during the progress of this complaint.

Crushing of the middle lobe of the prostate gland has occasionally been performed in cases in which this portion of the organ was a cause of retention of urine, the part being seized with a lithotrite and ground into small fragments, afterwards discharged along with the urine. The operation, however, is only applicable to the pedunculated form of the enlargement. When the tumor has a broad base, the proper procedure is perforation, either with a curved trocar or a conical silver catheter, a gum-elastic instrument being permanently retained until the new canal is measurably cicatrized. A surgeon who is rash enough to employ either of these expedients must be prepared for the worst, as the issue must frequently be fatal. A safer plan, in such a condition, would be the lateral perineal section, and the removal of the middle lobe with the probe-pointed bistoury, the urine passing off by the wound until the parts are healed.

Hypertrophy dependent upon the presence of morbid growths is entirely irremediable; palliation is all that can be hoped for, and even this is generally very unsatisfactory.

5. *Prostatorrhœa*.—*Prostatorrhœa*, an affection which I have been the first to describe, is, as the term implies, a discharge from the prostate gland, generally of a thin mucous character, dependent upon irritation, if not actual inflammation, of the component tissues of that organ; and liable to be confounded with other lesions, as seminal losses, gleet, and cystorrhœa, from which, however, it is usually easily distinguished.

Prostatorrhœa is rare in children and very young subjects, owing, no doubt, to the remarkably dormant condition of the genito-urinary organs in early life. It may, however, occur even at a very tender age, especially in children laboring under stone in the bladder, prolapse of the bowel, or worms in the rectum, causing reflected irritation. After the twentieth year, the disease is sufficiently common, and instances are occasionally witnessed even in very old persons. As long as the prostate gland remains small and inactive, or is not brought fully under the influence of the genital apparatus, with which it is so intimately associated, it is comparatively infrequent.

Although all classes of persons are liable to this affection, it has seemed to me to be most common in those of a sanguineo-nervous temperament, with strong sexual propensities, leading to frequent indulgence of the venereal appetite, if not to positive venereal excesses, whether in the natural manner or by masturbation. An irritation is thus established in the organ, attended with more or less discharge of its peculiar secretion, normal or abnormal. Single and married men are, apparently, equally prone to it. Intemperance in eating and drinking, frequent horseback exercise, sexual abuse, and disease of the bladder, anus, and rectum, may all be regarded as contributing to its production and maintenance.

The exciting causes are not always very evident. In most cases, the affection is traceable, either directly or indirectly, to venereal excesses, chronic inflammation of the neck of the bladder, stricture of the urethra, or disease of some kind or other of this canal. Sometimes it has its origin in disorder of the lower bowel, as hemorrhoids, prolapse, fissure, fistule, ascariides, or the lodgment of some foreign body. It is easy to conceive how reflected irritation might induce this disease. The connection between the prostate gland and ano-rectal region is very close and intimate, and, therefore, whatever affects the one will almost be sure, in time, to implicate the other, either from proximity of structure or as an effect of sympathy. Temporary *prostatorrhœa* is occasionally excited by the use of drastic cathartics, cantharides, turpentine, or, in short, whatever has a tendency to invite a preternatural afflux of blood to the prostate gland, the neck of the bladder, or the posterior portion of the urethra. Many of the most obstinate and perplexing cases of the disease that have come under my notice were the direct result of masturbation.

The *symptoms* are sufficiently characteristic. The most prominent is a discharge of mucus, generally perfectly clear and transparent, more or less ropy, and of varying quantity, from a few drops to a drachm and even upwards, in the four-and-twenty hours. It is seldom puriform, and still more rarely purulent. When considerable, the flow keeps up almost a constant moisture at the orifice of the urethra, and it may even make a decided impression upon the patient's linen, leaving it wet and stained, as in gleet, or gonorrhœa, although in a much less degree. The most copious evacuations of this kind generally occur when the patient is at the water-closet, engaged in straining, especially if the bowels are constipated, or the rectum is distended with hard fecal matter so as to exert an unusual amount of pressure upon the prostate gland.

The discharge, whether small or large, is often attended with a peculiar tickling sensation in the prostate gland, from which it frequently extends along the whole length of the urethra, and even to the head of the penis. In many cases, the feeling is of a lascivious, voluptuous, or pleasurable nature, not unlike that which accompanies the earlier stages of sexual intercourse. Very often there is a "dropping sensation," as if the fluid were falling from the prostate gland into the urethra. Other anomalous symptoms sometimes present themselves, as a feeling of weight and fatigue in the region of the prostate, anus, and rectum, or along the perineum, with, perhaps, more or less uneasiness in voiding urine, and a frequent desire to empty the bladder. Some patients are troubled with morbid erections and lascivious dreams.

The patient's mind is generally very seriously involved in this affection. The discharge, even if ever so insignificant, occasions him the greatest possible disquietude; for at one time he imagines that it is a source of much bodily debility, or that it is productive of weakness and soreness in the dorsolumbar region, especially if these

symptoms happen to coexist; at another, that he is about to become impotent, under the delusive idea that the flow is one of a seminal character, an idea which not unfrequently haunts him day and night, and from which hardly anything can, perhaps even temporarily, divert his attention. His mind, in short, is poisoned, and the consequence is that he is incessantly engaged in trying to obtain relief, running from one practitioner to another, distrusting all, and affording none an opportunity of doing him any good. In the worst forms of the affection, his business habits are destroyed, he becomes morose and dyspeptic, and he literally spends his time in watching for the discharge which is the source and cause of his terrible suffering.

The *diagnosis* is generally unequivocal. The affections with which the disorder is most liable to be confounded are the different forms of urethritis, especially gleet, spermatorrhœa, and cystorrhœa. From inflammation of the urethra it is always readily distinguished by the absence of pain and scalding in passing water, by the small quantity and transparent character of the discharge, and by the history of the case. In gleet, the secretion is always opaque, and usually leaves a permanent stain upon the patient's linen. In spermatorrhœa, the discharge commonly occurs at night, during a lascivious dream, and is much more copious than in prostatorrhœa. In cystorrhœa, or chronic cystitis, the mucus, which forms the characteristic feature of the complaint, is only voided during micturition, and is invariably dependent upon organic disease of the bladder. In case of doubt, the suspected fluid should be examined with the microscope, and, in doing this, it must not be forgotten that the discharge in prostatorrhœa occasionally contains a few spermatozoa.

The *pathology* of this affection seems to consist in an exalted functional activity of the follicular structure of the prostate gland, leading to an inordinate secretion and discharge of its peculiar fluid. That it is occasionally of an inflammatory nature is highly probable, but there is no reason to believe that this is generally or even frequently the case. In many instances, it is, apparently, due to reflex irritation, provoked by disease of the genito-urinary organs, the anus, and the rectum.

The *prognosis* is generally favorable. The obstinacy of the discharge, however, is often very great, and a rapid cure need, therefore, seldom be anticipated, especially when the mind is totally absorbed in the local affection, as is so often the case in young men of a nervous, irritable temperament. In such an event, there is no complaint which, according to my experience, is more difficult of management, or more likely to result in vexation and disappointment.

In the *treatment* of prostatorrhœa, one of the first and most important points is to ascertain, if possible, the nature of the exciting cause. With this view, the genito-urinary apparatus and the lower bowel should be thoroughly explored with the bougie, the finger, and even, if necessary, the speculum, so that any irritation that may be found in them may be promptly corrected, as a preliminary step to the employment of other measures. The general health must be improved by exercise in the open air, by the cold shower-bath, by a careful regulation of the diet, and by a course of chalybeate tonics, in union with quinine and strychnia. Venereal excesses must be refrained from, as tending to keep up undue excitement in the prostate gland, the seminal vesicles, and the adjoining structures. For a similar reason, drastic purgatives, horseback exercise, high-seasoned dishes, condiments, wine, and alcoholic stimulants are interdicted. The bowels are maintained in a soluble condition. The best local remedies, according to my experience, are anodyne suppositories and injections of a solution of Goulard's extract, in the proportion of about one drachm to ten ounces of water, repeated night and morning, and retained for at least five minutes at a time. If the patient is plethoric, blood may be taken by leeches from the perineum, and the system reduced by antimonial and saline preparations, in combination with light diet and other depressing measures. In obstinate cases, cauterization of the prostatic portion of the urethra sometimes affords prompt relief.

Whatever may be the plan of treatment, perseverance and an occasional change of prescription are indispensable to success. When there is deep mental involvement, hardly anything will effect a cure; or, more correctly speaking, it will be almost impossible to induce the patient to believe that he is well, or that nothing serious ails him. Under such circumstances, the chief dependence must be upon travelling and an entire change of scene and occupation. Matrimony should be enjoined, if the patient is single.

6. *Tumors or Morbid Growths.*—*Carcinomatous* formations of the prostate are extremely uncommon. The most frequent, undoubtedly, is encephaloid, but even

this is very rare. It has hitherto been observed chiefly in advanced life, although no period seems to be exempt from it.

There are no signs by which encephaloid can be distinguished, with any clearness, from some of the other affections to which this body is liable. The most reliable evidences are, a discharge of blood with the urine, the occasional expulsion of cerebriform substance or organized clots, the frequent desire to pass water, and the ability to feel the enlarged gland through the rectum. No kind of treatment, either local or general, is of any service beyond palliation.

Of scirrhus of this gland nothing is known, and the same is true of colloid and melanosis. Their occurrence is extremely rare, and, excepting the latter, I have never met with them in this situation. In the case referred to, the black deposit existed in the bladder, and in almost every other organ of the body, without any suspicion, during life, of its presence in the urinary apparatus. The patient was a man, fifty-eight years of age.

Cysts occasionally exist in the prostate, as the result of obstructed and dilated follicles or tubules, but their occurrence is very uncommon. They vary very much in size and number, but are usually quite small. Their contents are transparent, fluid, and of a serous character. Old persons are most subject to them. When a cyst of the prostate attains a large bulk, its inevitable tendency is, by the constant pressure which it exerts, to cause atrophy of the organ; or, in other words, to usurp its place. Should the cyst, under such circumstances, burst, or be accidentally ruptured, a large cavity will thus be formed, which may afterwards serve as a kind of subsidiary pouch for the lodgment of urine and the development of calculi. Such a receptacle might seriously interfere with the introduction of the catheter.

Myomatous fibromas, the so-called prostatic glandular tumors, are not of uncommon occurrence in the enlarged organ of elderly subjects, in which they are found under two very distinct forms. In one of these the morbid growth is imbedded, more or less deeply, in the substance of the gland, where it is distinctly encapsuled, and easily enucleated. Generally solitary, it is of a rounded or ovoidal shape, and ranges in volume from that of a pea to that of a filbert. In the other variety the tumor occurs as an outgrowth, continuous with the organ by a narrow pedicle, the whole resembling a polypoid excrescence, of varying size and form, and often obstructing the orifice of the urethra. Both classes of tumors are identical in structure with that of the proper prostatic tissue, being composed of fibro-muscular and glandular elements, the former predominating. From this fact they are more correctly denominated myo-fibromatous growths, and should not be included among the adenomas, as there is no true hyperplasia of the gland-follicles. Their existence may be suspected, but cannot positively be affirmed during life, and surgery furnishes no means for their removal. I have on several occasions accidentally enucleated such growths in the lateral operation of lithotomy, and have found that the closure of the wound was thereby retarded.

7. *Tuberculosis*.—The prostate gland is occasionally the seat of tubercles. The affection, however, is also extremely rare, and is usually, if not invariably, associated with similar deposits in the seminal vesicles, urinary bladder, kidneys, testicles, and other organs. The malady is most common between the twenty-fifth and fifty-fifth years. In eighteen cases analyzed by Sir Henry Thompson, in his excellent work on the Prostate Gland, the age of the youngest subject was eleven and of the oldest seventy-six years.

The disease furnishes no characteristic symptoms, and every attempt to treat it upon scientific principles must prove unavailing. When its existence is suspected, iodine may be administered internally, and counter-irritation applied to the perineum.

8. *Hemorrhage*.—The prostate gland is liable to hemorrhage, varying in degree from a few drops to several ounces. The occurrence, however, is very rare, and is chiefly met with in aged subjects, in consequence of the forcible use of instruments. Sometimes the most gentle catheterism will be followed by a smart flow of blood. The irritation of a calculus may also give rise to it. The diagnosis is uncertain, as it is difficult to determine the precise source of the bleeding.

The prognosis is favorable or otherwise, according to the cause of the hemorrhage, as, for example, whether it is simple or traumatic, or dependent upon ulceration of the gland, or the presence of malignant disease. The treatment is to be conducted upon the same principles as in hemorrhage of the urinary passages generally.

9. *Calculi*.—The prostate, like the bladder and the kidney, is liable to the formation of calculi, as seen in fig. 604, which generally become a source of severe suffering, imperatively demanding surgical and other interference. They are entirely different, both in their structure and composition, from vesical concretions, and appear to be the result, at least in most instances, of disordered follicular secretion, dependent, in all probability, upon subacute or chronic irritation. Old persons are most liable to their formation; they may, however, occur at almost any period of life.

The number of concretions is extremely variable; sometimes there is only one, while, at other times, there are so many as to render it difficult to count them. Their volume is generally in proportion to their number. Composed exclusively of phosphate of lime, they are of a spherical or ovoidal shape, of a firm consistence, and of a grayish, whitish, or brownish color. From a careful examination of their situation, in different stages of their development, I am led to believe that they are originally formed in the follicles and ducts of the prostate, from which they either escape, or they remain, and gradually destroy its substance.

A very remarkable specimen of prostatic calculus, delineated in 605, and now contained in the Museum of the Royal College of Surgeons in London, has been described by Dr. Herbert Barker, of England. Its weight was three ounces and a half, its length nearly five inches, and its circumference, at the thickest part, four inches and five-eighths. It had a rough, lobulated surface, and consisted of twenty-nine distinct pieces, clearly showing that it had been originally deposited in separate follicles of the prostate, the intervening structures of which had been absorbed during the progress of its formation.

There is no uniformity in the effects produced by these bodies. When small, they seldom cause much uneasiness, sometimes, indeed, not the slightest. At times, however, they are productive of great inconvenience, if not of excessive suffering. One of the most common occurrences is a dull, aching, wandering pain, with a sense of uneasiness in the perineum and neck of the bladder. The general symptoms do not differ materially from those of stone in the bladder.

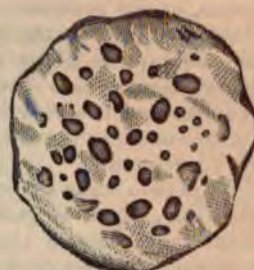
The diagnosis is by no means always easy. When the finger is introduced into the rectum, and the prostate is pressed backwards with a large sound, the concretions may often be felt as so many hard, irregular projections, the position of which remains unchanged by any force that may be applied to them. When a considerable number are collected together, as it were, in a nest, they impart to the finger the feel of a bag of marbles, of a mass of clotted blood, or of a bag of air. Another sign upon which great reliance is placed is that the concretions can be felt only in one particular spot, and that they are generally more or less immovably fixed.

Prostatic calculi are usually associated with disease of the urinary apparatus, as stricture of the urethra, hypertrophy of the muscular coat of the bladder, vesical calculi, and disorganization of the ureters and kidneys. The prostate itself is variously affected; generally, it is atrophied, and partially sacculated.

The treatment is palliative and radical. The former consists in improving the general health, and removing any local complications that may exist. The tendency to phosphatic deposits is counteracted by the use of the different acids, especially the nitric, either singly or in union with infusion of uva ursi and hops. The use of alkalies is also sometimes indicated.

The radical treatment, which, of course, is purely mechanical, must be regulated by circumstances. When the calculi project into the urethra, they may sometimes be detached with an instrument, and pushed back into the bladder, or an attempt may be made to seize and remove them with Weiss's forceps. When they are encysted, or contained in a bag in the parenchymatous substance, the only way is to cut down to the organ upon a staff, as in the ordinary operation of lithotomy. When the

Fig. 604.



Prostatic Calculi.

Fig. 605.



Prostatic Calculus.

calculi lie in the cellular substance between the prostate and the rectum, extraction may advantageously be effected through the bowel, previously well dilated with the speculum.

10. *Sacciform Disease and Fistule*.—In consequence of abscess, ulceration, gangrene, or the presence of calculi, a pouch, sometimes as large as a pullet's egg, is liable to form in the prostate gland, at the expense of its proper substance, its fibrous capsule alone remaining. In the majority of cases it communicates by a pretty large orifice directly with the bladder, so that, if a catheter is passed along the urethra, it is very apt to become arrested in it. Occasionally it opens into the rectum or upon the surface of the perineum, or in both situations, although this is very uncommon.

A person thus affected experiences more or less pain and difficulty in voiding his urine, which is generally mixed with pus and thick, ropy mucus; there is constant uneasiness in the pelvic region, the general health suffers, and the slightest exposure, fatigue, or disorder of the bowels, is sure to aggravate the local distress. When the sac communicates with the bowel, there may be an interchange of urine and fecal matter between the two reservoirs. Sometimes there is incontinence, at other times retention, of urine. The diagnosis can only be established by a thorough exploration with the catheter, aided by the finger in the rectum. The prognosis is unfavorable, as few cases admit of relief by treatment. When the suffering is very great, the best plan is to divide the parts freely, as in the recto-vesical operation of lithotomy.

CHAPTER XVIII.

DISEASES AND INJURIES OF THE MALE GENITAL ORGANS.

SECT. I.—AFFECTIONS OF THE TESTICLE.

THE testicle is liable to congenital irregularities, wounds, inflammation, abscess, atrophy, cystic disease, various degenerations, morbid growths, and neuralgia.

1. *Congenital Irregularities*.—One of the testicles is sometimes absent, the increased size of the other generally atoning for the deficiency. Only a few instances of a well-authenticated character are upon record in which both organs were wanting. Sometimes one testicle is unusually small, and the other uncommonly large. I have met with two cases in which these structures seemed to exist simply in a rudimentary state, their volume hardly equalling that of a hazelnut. One of the men never experienced the slightest sexual desire; the other, however, had been married, but, although the connection had lasted upwards of twenty years, no offspring had followed. A supernumerary testicle occasionally exists, but, in general, what is regarded as such an appendage is merely a fatty or fibrous tumor of the scrotum, or a portion of irreducible omentum, as in the celebrated case of Morgagni.

Anomalies of situation of the testicle sometimes occur. Of these, the most common is the retention of the organ in the groin, or in the inguinal canal; more rarely it remains in the cavity of the abdomen. The defect may be limited to one organ, or it may involve both; and, what is singular, it now and then occurs in several members of the same family, as in a remarkable instance reported by me in the *Western Journal of Medicine and Surgery*, for May, 1841. In time—generally towards the age of puberty, or soon after—the organ passes down into the scrotum, but the cases are not uncommon where the retention is permanent. Besides being a source of pain and annoyance in such an event, from the compression of the abdominal muscles and other causes, the organ is prone to take on encephaloid disease and to induce hydrocele and hernia. It is asserted that an undescended testicle is incapable of forming spermatozoa. If hernia should occur, the protruding parts, instead of issuing at the external ring, are very apt to be deflected out towards the anterior superior spinous process of the ilium, thus constituting, strictly speaking, an inguinal hernia or bubonocoele.

The tumor formed by an undescended testicle is liable to be mistaken for hernia; but from this it may generally be easily distinguished by its greater solidity, by the empty state of the scrotum, by the absence of impulse on coughing, and by the peculiar pain felt on handling the parts. When the tumor coexists with hernia, the symptoms will be of a mixed character.

The treatment of retained testicle varies. When the organ lies in the groin, an attempt should be made by daily and long-continued tractions with the fingers, aided by gymnastic and other exercises, to get it into the scrotum. If it is only partially down, and there is at the same time a hernia, a truss with a small pad should be worn, the pressure being applied above the retained organ, which may then be gradually urged down by the means just mentioned. Nothing, of course, can be done when the testicle is retained in the abdominal cavity. When the gland suffers excessive pain from the incessant compression of the abdominal muscles, extirpation may become necessary.

Instead of being retained in the groin, the testicle sometimes descends into the perineum, lying at the root of the scrotum, near the anus, or close by the tuberosity of the ischium. Such an anomaly, of which interesting examples have been observed by Hunter, Ricord, Partridge, Vidal, Sands, and others, always constitutes a serious evil, as it must necessarily be attended with great inconvenience and risk of injury when the subject of it sits, or rides on horseback. Attempts have been made in some of the recorded cases to replace the organ by an operation, but thus far without success, and hence the best plan is to sacrifice it. In an instance observed by Zeiss, the organ occupied the left side of the perineum, and offered a serious obstacle to the operation of lithotomy.

Eckart and Vidal each relate an instance in which one of the testicles, instead of passing through the inguinal canal, emerged at the femoral ring; and Curling refers to one in which this gland was lodged behind the saphenous vein, in the upper and inner part of the thigh, about three inches below Poupart's ligament. It was small and undeveloped. Finally, the position of the testicle in the scrotum is sometimes reversed, the free surface presenting posteriorly, while the anterior part of the organ is connected with the epididymis.

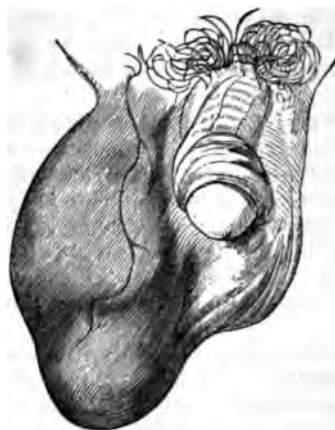
2. *Wounds.*—Wounds of the testicle may be of various kinds, as incised, contused, punctured, lacerated, and gunshot; their occurrence is uncommon, and their treatment does not differ from that of similar lesions in other parts of the body. Great care should be taken to save as much structure as possible. When the wound extends through the spermatic cord, serious hemorrhage may arise, and it should, therefore, be the duty of the surgeon to seek for and tie every bleeding vessel.

A violent contusion of the testicle has been followed by convulsions and death. Even in the milder grades of the injury there is often most intense pain, extending along the groins to the loins, and attended with a peculiar sickening sensation, sometimes amounting to complete syncope. The patient is obliged to double himself up for relief, breaks out into a copious sweat, and is seized with nausea, if not vomiting. The shock, in fact, is excessive. The suffering, however, is commonly very transient, and subsides either spontaneously or under the influence of cold air and gentle stimulants. More or less blood is generally extravasated, as a consequence of the lesion, either into the vaginal sac, or between the sac and the albugineous coat. Sometimes the fluid is extensively effused into the cellular tissue of the spermatic cord, the infiltration reaching, perhaps, as high up as the internal abdominal ring, the kidney, or even the diaphragm, as in the interesting case related by Petit.

Wounds of the testicle are liable to occasion atrophy. In a case which occurred in the Crimean war, and in which a very slight injury had been inflicted by the fragment of a shell, the organ had nearly entirely disappeared at the end of five months by absorption. The other testicle was also diminished in bulk, although it did not seem to have been hurt in the first instance. A similar phenomenon was noticed by Jobert in some of the persons that were wounded in the insurrection at Paris, in July, 1830.

When the testicle is completely denuded, whether by accident or disease, a covering may be formed for it by the transplantation of a flap of integument from the thigh and perineum. In a case reported by Professor Falton, of Toronto, the proceeding was followed by the most gratifying results. The man had been wounded

Fig. 606.



Acute Orchitis.

in a threshing machine, one testicle being torn off with a portion of the spermatic cord, and the other completely divested of skin. The greater portion of the flap united by the first intention.

3. *Orchitis*.—Inflammation of the testicle, technically called orchitis, may be acute or chronic, idiopathic or traumatic, primary or consecutive, common or specific. For an account of the syphilitic form of the affection, the reader is referred to the chapter on syphilitic diseases in the first volume.

The acute form of common orchitis is seated principally in the epididymis, and is generally caused by gonorrhœa, the inflammation being transmitted from the urethra along the deferent duct. It may also be occasioned by external violence, great sexual excitement, the effects of cold, and by metastasis, as in mumps. During the existence of gonorrhœa, the most trifling circumstances, as the pressure of the pantaloons, exposure to wet, fatigue, and stimulating injections, may induce the disease. The

epididymis, enlarged to twice or thrice its natural volume, is abnormally firm, and the vaginal tunic is distended with turbid serum, intermixed with flakes of lymph. The testis itself, as seen in fig. 606, is comparatively little increased in size. The part is exquisitely tender, and intolerant of the slightest pressure; the pain is of a dull, heavy, aching, sickening character, and extends upwards in the course of the spermatic cord as far as the loins, where it is often very severe; the scrotum is hot, tense, red, and glistening; high fever is present, frequently accompanied by nausea and vomiting; and, if blood be drawn from the arm, it is usually found to be sized and cupped. The discharge from the urethra is very much diminished, or entirely suspended, and the patient is often annoyed with nocturnal emissions, tinged with blood. In many cases great uneasiness is felt in the groin, abdomen, hip, perineum, and upper part of the thigh. When the epididymitis, as this affection is properly designated, follows upon gonorrhœa, it usually comes on about the end of the third or the beginning of the fourth week of the attack of this disease, although it may occur much earlier, as well as much later. It often affects both glands, either simultaneously or successively. Verneuil has noticed the singular fact that orchitis, especially when accompanied by copious serous effusion into the vaginal tunic, is frequently complicated with inflammation of the throat.

The power of furnishing spermatozoa is often seriously impaired, if not completely destroyed, by the effects of orchitis, or of this disease and of epididymitis, whether the result of gonorrhœa, syphilis, parotitis, or external injury. Hence, if both glands have suffered severely, the individual may be permanently impotent, although it is possible for the organs, ultimately, to regain their natural functions. Fortunately such a condition does not weaken the sexual appetite, or the power of gratifying it; and, as there is always an evacuation of seminal fluid during copulation, the subject of it is never aware of his real situation. It will thus be seen that orchitis is a grave affection, independently of the local and general suffering it occasions.

A testicle retained in the groin may take on inflammation, and thus occasion a train of phenomena closely resembling strangulated hernia, especially when the accident occurs in the adult. The principal signs of distinction are, the absence of the testicle from the corresponding side of the scrotum, the history of the case, the uniform hardness of the swelling, the sickening pain produced on pressure, and the facility with which the bowels are relieved by purgative medicine. The two affections may coexist, and then the tumor will probably be hard at one point, and more or less soft at another. From the close proximity of the testicle to the peritoneum, the inflammation may readily be propagated to that membrane, and in this way a case, which is ordinarily comparatively harmless, may become one of a very dangerous character, occasionally terminating in sloughing and even in death.

The treatment is rigorously antiphlogistic. If the patient is young and plethoric, blood is freely taken from the arm; the bowels are evacuated with senna and Epsom salt, or calomel and jalap; antimony is given in small doses, to keep up nausea;

the recumbent posture is observed; and the scrotum, suspended with a folded handkerchief, is diligently fomented with the lead and opium lotion. Cold applications, seldom agreeable to the patient, are often positively injurious. Blood may sometimes be abstracted advantageously by puncture from the veins of the scrotum, or by leeches from the groin, perineum, or inside of the thighs. Occasionally the animals are applied directly to the inflamed surface.

When the swelling is very large, tense, and painful, a tolerably free incision should be made to afford vent to the pent-up serum, which, whenever the disease is unusually severe, is always present in greater or less quantity, and thus adds greatly to the patient's suffering. In performing the operation, the testicle is grasped at its lower and back part with the left hand, while with the right a narrow, sharp pointed bistoury is plunged perpendicularly into the fluctuating mass above and in front. The want of resistance and the escape of fluid will indicate that the instrument has been carried to the requisite depth. If prompt and decided relief do not follow this proceeding, the knife is reintroduced so as to divide tolerably freely, at one or more points, the albugineous tunic, in order to remove the excessive pressure which it exerts upon the inflamed and sensitive tubular structure beneath. Such an operation, however, will seldom be necessary.

As soon as the disease loses its acute character, as it usually does under the above measures in three or four days, the gums should be gently touched with mercury, and the affected part compressed with a series of strips of adhesive plaster, each about six lines in width, and eight inches in length. The strips are applied as in fig. 607 which explains the process much better than any formal description. The first is placed circularly around the cord, just above the epididymis, as tightly as it can be borne; the second slightly overlaps the first, the third the second, and so on until the whole tumor is enveloped down to its base, when five or six vertical strips complete the dressing.

The patient usually experiences some degree of pain during and immediately after the operation, and should this not subside in an hour or two the compression must be discontinued. The strapping requires to be renewed every twenty-four hours. The advantage of this treatment is that, while it rapidly subdues the disease and promotes the absorption of effused fluids, the patient is able to walk about and attend to business.

4. *Suppuration and Abscess.*—Orchitis does not often pass into suppuration, much less into abscess. When matter is about to form, all the symptoms are suddenly aggravated; rigors come on, often attended with slight delirium; and the part is so painful as to be intolerant of the slightest manipulation and pressure. The pus, generally mixed with seminal fluid, is seldom of a healthy character; and, as it is confined by the albugineous coat, it is always a long time in reaching the surface. The abscess often breaks at several places, thus leaving unhealthy sores, which it is difficult to heal, and which not unfrequently lead to a total disorganization of the tubular structure. Suppuration of the testicle is most common in scrofulous subjects, and in persons affected with tertiary syphilis. The matter is sometimes encysted, as in fig. 608. When pus forms as a consequence of ordinary epididymitis, it is generally situated in the vaginal tunic, and not in the substance of the testicle.

A very remarkable case of abscess in an undescended testicle has been related by Dr. M. M. Eaton, of Peoria, Illinois, in the *Chicago Medical Examiner*. The patient, sixteen years of age, had an exquisitely tender tumor, the size of an orange, in the right iliac region, and died under all the symptoms of acute peritonitis. The testicle,

Fig. 607.



Strapping of the Testicle.

Fig. 608.



Abscess of the Testicle.

fibrous degeneration. The change consists in hyperplasia of the interstitial connective tissue, which is gradually converted into white, grayish, or bluish filaments, narrow, dense, resisting, and interlaced in every conceivable manner. The new tissue interferes so much with the nutritive condition of the seminiferous tubes as to occasion, at first, a diminution in their size, and ultimately their entire destruction. When the transformation is complete, the organ is firm, solid, almost incompressible, inelastic, destitute of moisture, and creaking under the knife. Small cysts, containing serous fluid, are occasionally interspersed through it, and specimens are observed in which there are tolerably large cavities filled with whitish, jelly-like matter. The tumor rarely exceeds the volume of a common-sized orange. The vaginal and albuginous tunics often preserve their natural characters. The disease has no tendency to return after removal. The annexed sketch, fig. 610, from a preparation in my collection, conveys a good idea of the peculiar structure of this morbid growth.

The history of the case, the chronic course of the disease, the absence of pain, the freedom from lymphatic involvement, the integrity of the spermatic cord, and the great firmness of the tumor, readily serve to establish the diagnosis between this and other affections of the testicle.

The microscopical characters of fibrous degeneration of the testicle, consequent upon tertiary syphilis, are well illustrated in fig. 611, from a drawing by Dr. Packard. The patient, from whom I removed it, had been laboring under orchitis for nearly three years. The disease was attended with a large fungus and a most copious, fetid discharge; the general health was much undermined, and a painful node existed upon each tibia. The testicle was considerably reduced in size, and consisted mainly of fibrous tissue, interspersed with numerous nuclei, some adherent, others free. A more minute account of syphilitic orchitis will be found in the first volume.

When this disease is fully formed, and the substance of the testicle is completely annihilated, the only suitable remedy is extirpation. In its earlier stages, its progress may sometimes be stayed by sorbafacient applications, aided by occasional leeching and strapping, and by gentle but persistent ptyalism.

Calcification or ossification of the glandular structure of this organ is of very infrequent occurrence. The deposit may take place in any part of the testis, but is most common towards its centre, and is generally accompanied with considerable enlargement. It is often of an earthy rather than a bony nature, being nearly destitute of animal matter, and closely resembling the earthy substance found in the lungs and bronchial glands. Such a formation is exhibited in fig. 612, from a specimen in my possession. The organ, removed from a man, aged thirty, was greatly atrophied, and completely deprived of its natural structure.

The albuginous tunic of the testicle is sometimes ossified, as in a specimen kindly presented to me by Professor McGuire, of Richmond, Virginia, removed after death from a colored man, sixty-five years old. The testicle was much enlarged, the parenchymatous structure was completely annihilated, and the bony shell, several lines in thickness, and laminated in appearance, emitted, when struck, a peculiar sound, similar to that of a dice-box. The man had never complained of any pain.

Calcification of the vaginal tunic is an occasional occurrence, but seldom occupies

Fig. 611.



Microscopical Characters of Syphilitic Orchitis.

Fig. 612.



Calcareous Matter in the Testicle.

much extent, and is generally associated with the fibrous and cartilaginous degeneration.

Finally, the testicle occasionally undergoes the *fatty degeneration*, especially when it is habitually compressed, as when it is permanently retained in the groin, or imprisoned in an old rupture. In a case described by Follin, the form of the organ was normal, but its glandular texture was almost entirely replaced by a mass of yellow adipose matter and connective tissue. In other instances, the testicle is enlarged, and interspersed with cysts, some of large size, which are filled with atheromatous material, consisting of fat globules, granular corpuscles, and crystals of cholesterine in great abundance. The walls of the cyst are very thick, covered with granulations, and, in part, calcified. The intervening structure consists of broad bands of compact fibrous tissue, which isolate the cysts from the proper substance of the organ. In a third class of cases, the organ undergoes atrophy, as in the annexed sketch, fig. 613, copied from Curling, which represents the left testicle of a man, forty-six years of age, who died of dropsy, consequent upon disease of the kidney. The organ was reduced to one-fifth its natural size, and its wasted tubular structure was inlaid with fat-globules. Fatty matter was also found beneath the visceral layer of the vaginal tunic.

Fig. 613.



Fatty Degeneration of the Testicle: 1, the Epididymis; 2, Body of the Testicle; 3, Fatty Deposit.

Fig. 614.



Cystic Testicle.

7. *Cystic Disease*.—The testicle, as seen in fig. 614, from Curling, is sometimes the seat of cysts, varying in size from a mustard seed to that of a grape, a marble, or a pigeon's egg, and due to dilatation of, or outgrowth from, the seminal ducts. They are extremely delicate, vascular, gregarious, and filled with fluid, which, in accordance with their dimensions, may be gelatinous, glairy, and discolored by blood, fat-globules, and cholesterine, or, as more rarely happens, thin and watery, and analogous to the serum of the blood. Their number may not exceed six or eight, or there may be hundreds, if not thousands. In old cases, their coats are liable to become firm, opaque, and wrinkled, their contents being thick and glairy, like the white of egg, jelly, starch, or suct. The intermediate substance is connective tissue, at one time sparse and delicate, at another, dense, compact, and solid, in which nodules of cartilage are occasionally imbedded. The disease which is thus formed is of very slow growth, free from pain or constitutional disturbance, and most common between the twentieth and thirty-fifth year. It usually begins in the rete of the testis, the structure of which, together with that of the body of the organ and of the epididymis,

is ultimately entirely destroyed. The tumor may acquire the bulk of a large fist, or even of a foetal head, and is of an oval shape, opaque, heavy to the feel, and less fluctuating than hydrocele, with which it is liable to be confounded. The epididymis retains for a long time its natural outline. The spermatic cord and the glands of the groin are never contaminated, as in encephaloid. The veins of the scrotum are usually very conspicuous. The only remedy for this affection is excision, and it is gratifying to know that the operation, when properly performed, is never followed by relapse.

Cystic disease of the testicle is sometimes associated with *sarcoma*, thus rendering the prognosis, as it respects relapse after operation, very unfavorable. Here, as in the female breast, the interstitial connective tissue is replaced by sarcomatous structure, by which a portion of the tubules is compressed and choked up, while the remainder is dilated into cysts, some of which are filled with fluid, the majority, however, being occupied by pedunculated, dendritic, or papillary masses of the new growth, thereby giving rise to the affection known as proliferous cystic sarcoma. Under the influence of irritation, these tumors are liable to take on new action, increase rapidly, and exhibit the malignant features of ordinary medullary sarcoma in this situation.

Combination of cystic disease with *encephaloid* is also met with, the prognosis being still more unfavorable than in the former neoplasm. It is difficult, when this union exists, to determine whether the carcinomatous matter is superadded to the other during the progress of the case, or whether the two affections had a simultaneous origin; although the latter view appears to me to be the more consistent with modern research. The nature of the disease may be suspected, but cannot always be positively ascertained during life, when the morbid growth advances with unusual rapidity, when it attains an extraordinary bulk, and when there is great enlargement of the subcutaneous veins, with a tendency to disease in the spermatic cord and in the lumbar lymphatic glands.

In another class of cases, also very rare, the cystic disease occurs in union with *enchondroma*, the cartilage presenting itself either in the form of small, whitish nodules, occupying the connective tissue of the gland, or sending irregular, tortuous, or papillary prolongations into the cysts and the lymphatic vessels. However this may be, the adventitious material bears a strong resemblance, both in appearance, structure, and composition, to true hyaline foetal cartilage; its cells, however, are more delicate and more closely clustered together, and there is less uniformity in its color and consistence, especially the latter, which often exhibits no little variety, one portion being, perhaps, quite firm and almost dry, while another is very soft and succulent. The most important diagnostic phenomena are the extraordinary weight and hardness of the tumor, the former of which may reach four or five pounds. Important information in regard to the consistence of the morbid mass may be obtained from the use of the exploring needle. The prognosis does not differ from that of ordinary cystic disease of the testicle.

8. *Tuberculosis*.—Tuberculosis of the testis, in the form of cheesy nodules, is met with chiefly in young subjects of a strumous diathesis. The adventitious deposit, which is more frequent in the epididymis than in the body of the organ, exhibits the same features as in the lungs and lymphatic glands. It occurs in small, isolated masses, from the size of a pea to that of a bean, as in fig. 615, or in the form of infiltration, and, in time, often completely subverts the whole organ, transforming it into a yellowish, curdy, friable, cheese-like substance. The gland is always indurated, more or less altered in shape, and somewhat enlarged. Sometimes the tubercular matter is changed into a hard, cretaceous substance. The disease commences insidiously, is unaccompanied by pain or tenderness on pressure, and often remains stationary for months, if not years. Ultimately, however, the skin becomes adherent, and of a livid hue, the tubercular matter softens, and the resulting abscess bursts, leaving an ill-looking ulcer, which remains fistulous for a long time, discharging a thin, serous, or gleetty pus, often intermixed with semen, and particles of the morbid product.

Fig. 615.



Tuberculosis of the Testicle.

The treatment is conducted in accordance with the same principles as in tubercular disease in general. Due attention is paid to the secretions; the bowels are evacuated by mild aperients; the system is invigorated by tonics and alteratives, as cod-liver oil, quinine, iodide of iron, or Lugol's solution, with bichloride of mercury; and a light, but nutritious, diet is enjoined, with regular exercise in the open air. In short, the aim should be to maintain the general health in as good a state as possible. Any inflammation that may be present is to be combated by leeches, medicated lotions, and rest in the recumbent position. Matter is evacuated by free incisions; fungous growth is repressed by escharotics, or removed with the scissors; and sinuses are treated by astringent injections, or laid freely open with the knife. When the disease is indolent, the part should be pencilled every day with dilute tincture of iodine, or rubbed with some discutient ointment, as that of the biniodide of mercury, diluted with six, eight, or ten times its weight of simple cerate. Compression by means of adhesive strips, applied in the same manner as in epididymitis, often tends to promote the absorption of the adventitious matter, and to hasten the resolution of the tumor. When the organ is completely subverted in its structure, and traversed with sinuses, the proper remedy, of course, is excision.

9. *Encephaloid*.—The most common malignant disease of the testicle is encephaloid, soft carcinoma, or fungus hematodes, from which no period of life is exempt. It was formerly supposed that young persons were most frequently affected with it, but experience has shown this opinion to be erroneous. Of 51 cases collected by Mr. Ludlow, of London, 39 occurred from the twentieth to the fiftieth year, 5 before the fifth year, 1 from the fifteenth to the twentieth year, and 6 from the fiftieth to the seventieth year. Most of the cases in my own practice occurred in young adults. I have seen several instances of encephaloid of the testicle in which this organ was retained in the groin; and a case has been reported by Mr. Johnson, of London, in which the malady affected a testicle that had never left the cavity of the abdomen. It has been thought, and not without reason, that a retained testicle is, relatively speaking, more liable to suffer in this wise than one in the scrotum.

Encephaloid rarely occurs on both sides. The disease, which is always rapid in its progress, and is often associated with cysts, enchondroma, and sarcoma, begins in the body of the testis, from which it soon spreads to the epididymis, then to the cord, and finally to the lumbar lymphatic glands. The tumor is of a pyriform figure, being larger below than above, and somewhat flattened in front; knobby and irregular, pulpy and elastic, heavy, opaque, and devoid of fluctuation. The weight is occasionally enormous, as in a case recorded by Boyer, where it reached nine pounds. The volume ordinarily does not exceed a large fist or fetal head. Sometimes the testicle remains sound, but is completely encased in medullary matter. The disease is at first unattended with pain; but, as it advances, the suffering often becomes very great. In the latter stages of the complaint, the countenance exhibits the greenish-yellow hue so characteristic of the carcinomatous cachexia; and the tumor, red on the surface, and traversed by large subcutaneous veins, protrudes in its well-known form of a bleeding, brain-like fungus. Under the sloughing, discharge, and pain, of which the ulcer is the seat, and the consequent hectic irritation, the patient rapidly sinks. Death has been known to occur within four months from the first appearance of the disease; but the average duration of life is nearly two years. The prognosis is unfavorable; therapeutic measures are unavailing; and ablation, however early performed, is nearly always speedily followed by a recurrence of the disease. Cases of immunity from a relapse of five, nine, ten, eleven, and twelve years have been reported, respectively, by Baring, Meade, Curling, Cooper, and Hawkins. Such cases are, of course, exceptional, and, although exceedingly interesting in a practical point of view, cannot be regarded as examples for general operative interference.

The remaining varieties of carcinoma of the testicle do not demand any special notice. The occurrence of scirrhus is exceedingly problematical, modern histological research having failed to confirm the observations of the earlier pathologists. Colloid is unknown, while melanosis has occasionally been met with.

10. *Sarcoma*.—Of the malignant diseases of the testicle, next to encephaloid, the most common is medullary sarcoma, and their distinction is only possible with the aid of the microscope. In 1870, I extirpated the left testicle of a healthy, robust man, thirty-two years of age, which had a uniform, full, firm, and dense feel, without elasticity or apparent fluctuation at any point. There was not the slightest inequality of its surface; the scrotal coverings were sound and unadherent; the

superficial veins were normal; there was no evident involvement of the lymphatic glands; and the sac of the vaginal tunic was free from fluid; but the veins of the cord were enlarged and tortuous. After removal, the tumor, which had made its appearance nine months previously, and was latterly painful on pressure at its upper limits, was found to be of an ovoidal figure, somewhat flattened from side to side, and nearly nine inches in its transverse, by eleven inches in its vertical, circumference, with a weight of ten ounces. The cord and epididymis were uninvolved, and the albugineous tunic perfect. On section, the surfaces displayed a homogeneous, moderately firm structure, of a delicate rosaceous tint, with here and there points of linear injection, easily broken down on pressure, and exuding a milky juice on scraping. Its microscopic character was that of small round-celled sarcoma. At the present date, two years subsequent to the operation, there has been no return of the disease.

Sarcoma does not always pursue the flattering course as in the case just narrated. On the contrary, when it arises in the epididymis, or when it perforates the albugineous coat of the testicle, it soon invades the cord and lumbar glands, and infects distant organs. These eminently malignant features are particularly evident when the disease is combined with carcinoma, in which event the organ attains huge proportions, cases having been observed in which it weighed fourteen and even fifteen pounds. Anatomically such tumors consist of a soft, spindle-celled stroma, containing alveoli filled with epithelial elements.

11. *Enchondroma*.—Of the different glands, next to the parotid, the testicle seems to be the favorite seat of the cartilaginous tumor, where, as already stated, it is usually combined with cysts, sarcoma, or encephaloid, although pure forms, of a hyaline constitution, and rarely exceeding the volume of a hen's egg, are met with. In the majority, if not all, of the instances, indeed, of association of cysts with enchondroma, there is every reason to believe that the latter is the primary affection, the former being due to partial occlusion and ectasy of the seminiferous tubules, through the compression exerted upon them by the new material, developed at the expense of the intertubular connective tissue. Arising usually in the rete of the organ, the cartilaginous tumor very frequently shoots prolongations into the lymphatic vessels, which exist in great numbers between the tubules, thereby giving the mass a peculiar tortuous and ramified appearance. The diagnosis is based upon the weight, hardness, and slow progress of the growth. The prognosis is commonly favorable. The general dissemination of enchondroma by means of the lymphatic vessels is well shown by a remarkable case of unmixed tumor, removed by Paget from a man, thirty-seven years of age, death having occurred from lung complications a few weeks subsequently. Two enlarged, varicose lymphatics, filled with cartilage, were traced along the spermatic vessels, from one of which a small mass projected into the vena cava; while the lungs were dotted, and the larger branches of the pulmonary artery infiltrated, with similar deposits. If, after having existed for several years as a painless, circumscribed swelling, such a tumor suddenly, rapidly, and painfully enlarges, the development of sarcoma may be suspected.

12. *Myomatous and other Tumors*.—Among the rarer neoplasms of the testicles are muscular tumors, formed principally of striated fibres, examples of which have been reported by Rokitansky, Rindfleisch, and Billroth. Their presence may be suspected by their congenital origin, firm, elastic consistence, and small volume. *Hydatids* are so uncommon as not to demand any special notice. A few instances have been observed, chiefly among the inhabitants of the tropics, in which this organ contained a cyst, occupied by the *filaria medinensis*, or guinea worm. *Dermoid cysts* are treated of in the section on affections of the scrotum.

13. *Atrophy*.—Atrophy of the testicle may be induced by a great variety of causes, as excessive venery, masturbation, external violence, wounds, mechanical pressure from tumors, effused fluids, or enlarged veins, obliteration of the spermatic artery, lesion of the cerebellum, and the inordinate use of iodine, alcohol, and narcotics. Occasionally it follows neuralgia and acute orchitis. The wasting, which is usually very gradual, is most common in young subjects, and often reduces the gland to a soft, pulpy structure, less than one-third the natural volume. The treatment is restricted, in great measure, to the removal of the exciting cause. Restoration of the normal bulk is hardly possible.

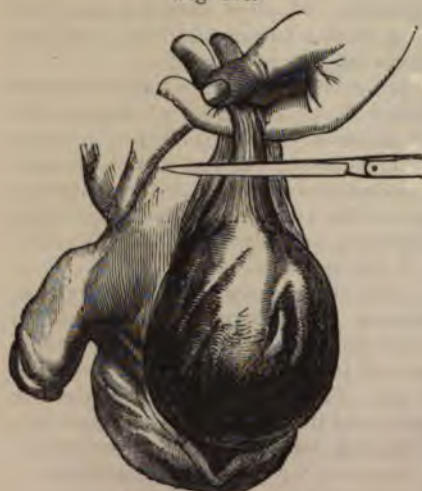
14. *Neuralgia*.—Neuralgia of the testis is chiefly observed in young subjects, of a nervous, irritable temperament, and generally arises without any obvious cause, although in many instances it is referred to external violence, stricture of the urethra,

or disease of the prostate gland, bladder, or rectum. In most of the cases that have fallen under my notice, it was connected with dyspepsia and neuralgia of other organs. Masturbation, venereal excesses, and varicocele occasionally induce the disease. In some cases it is of a distinctly malarious origin. It is characterized by constant uneasiness, excessive morbid sensibility, and violent darting pain, which is frequently paroxysmal, is aggravated by the slightest motion and pressure, and always extends to the neighboring parts, particularly the spermatic cord, back, and groin. Occasionally the pain is of a dull, heavy, aching nature, circumscribed instead of diffused, and relieved rather than increased by exercise. During the height of the suffering the testicle is closely retracted, and intolerant of the slightest manipulation. In protracted cases, the general health is always materially impaired; the digestive organs are disordered; and the patient is a prey to despondency and unpleasant foreboding. There is no swelling of the testicle, and generally no perceptible alteration in its structure. Occasionally, however, it is very much wasted, if not entirely destroyed. The cord is usually sound.

The treatment is similar to that of neuralgia in other parts of the body. After a preliminary course of moderate purgation, which should never be neglected, much may be expected from a combination of quinine, aconite, strychnia, and arsenic, as recommended in a former chapter. Low diet, mercury, and bloodletting generally aggravate the complaint. Stramonium is sometimes efficacious. The best local remedies are belladonna, aconite, and veratria, either in solution or in the form of ointment, rubbed on the scrotum and groin twice in the twenty-four hours. Temporary relief often follows the application of warm water. In some instances I have derived signal benefit from the application of a small blister to the groin, succeeded by the endermic use of sulphate of morphia. The organ must be properly suspended and protected from pressure. Castration can never be justifiable, not even when there is hopeless atrophy, inasmuch as the neuralgia would be certain to locate itself upon some other structure.

15. *Castration.*—Excision of the testicle, rendered necessary on account of different diseases, is generally a very simple operation. If the integument is not involved, a single incision will suffice, extending from the upper to the lower part of the tumor, along its anterior surface; otherwise it must be of an elliptical form. Great care, however, must be taken not to remove too much substance, as will be likely to be done, if proper allowance is not made for shrinkage. The tumor during this stage of the operation is supported with the left hand, applied to its posterior surface. The next step consists in detaching the spermatic cord from the surrounding parts, and cutting it off just above the tumor, as in fig. 616; but before this is done

Fig. 616.



Excision of the Testicle.

it is seized with a double hook, and drawn down, until its vessels are secured. A long, stout ligature being now passed through its connective tissue, but not tied, so that, in the event of secondary hemorrhage, the cord may at any moment be pulled out, the instrument is removed, and the organ rapidly detached from above downwards. In doing this, care must be taken not to wound the sound testicle, or to divide the scrotal septum. When the cord is diseased, it may be necessary to extend the dissection into the inguinal canal, and to include the whole mass in a strong thread previously to its division. In a case of incipient encephaloid of the testis upon which I operated in 1863, with the assistance of Dr. F. F. Maury, I included the entire cord, although perfectly sound, in a wire ligature left permanently in the groin. No unpleasant effects whatever followed. In a case in the practice of Mr. Chandler, of London, in 1807, in which the whole cord was tied by a single ligature,

tetanus set in on the ninth day, and terminated fatally in forty-eight hours. From three to six little arteries will generally require ligation, and it will be well not to

slight any vessel of this kind, however insignificant, otherwise secondary hemorrhage will almost be inevitable. The edges of the wound should be approximated with metallic sutures, but not until the skin has become thoroughly contracted, which will seldom be under five or six hours. To prevent hemorrhage, and promote cicatrization, the parts should be well supported, and kept constantly covered with a small bladder partially filled with pounded ice. Any tendency that may occur to inversion of the edges of the wound should be counteracted by the use of adhesive strips.

Instead of employing the ordinary dressings, I have on several occasions brought the deep portions of the wound closely together by means of several twisted sutures, by transfixing the flaps near their points of junction, and then throwing the ligatures around the pins over the edges of the wound. This procedure not only greatly promotes union by the first intention, but is one of the best safeguards against the occurrence of hemorrhage.

When disease of the testicle, requiring removal, is associated with scrotal hernia, the parts should be reduced previously to the operation, which should then be conducted in the usual manner, care being taken not to wound the sac.

When a testicle, the subject of malignant disease, is situated in the groin, safe removal can only be effected by the most patient and cautious dissection. Unless unusual care be taken, there will be great danger of wounding the peritoneum, if not also the bowel and omentum, especially if the affection coexists with inguinal hernia, and of thus lighting up fatal inflammation. The principal incision should be carried in the same direction as in the operation for the relief of strangulated hernia, only somewhat higher up, and free use made of the grooved director in dividing the superimposed structures. As the diagnosis is generally obscure, the first step should be of an exploratory character. As the cord requires to be divided unusually high up, the securest plan is to include it, vessels and all, in a wire ligature left permanently in the parts.

Ordinary castration is commonly a perfectly safe procedure. I have myself never met with any serious accident. The chief sources of danger are secondary hemorrhage, erysipelas, pyemia, and peritonitis. The latter affection will be most likely to occur when the dissection is extended very high up into the inguinal canal. Secondary hemorrhage is a great evil after this operation, as, from the infiltrated condition of the connective tissue, it is not only very difficult to tie the bleeding vessels, but the disturbance thus occasioned may lead to copious and troublesome supuration. A considerable number of cases of successful self-castration have been recorded.

16. *Bandages for the Testicle.*—Various contrivances may be employed for supporting a diseased testicle, rest being of great importance in all affections of this

Fig. 617.



Gum-elastic Suspensory.

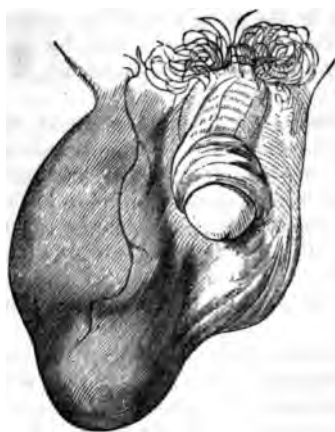
Fig. 618.



Mayor's Suspensory Apparatus.

organ, as well as in those of the vaginal tunic, the scrotum, and the spermatic cord. The article usually preferred is the ordinary gum-elastic bag, represented in fig. 617, or a bag made of knit silk, both of which have the advantage at once of softness, lightness, and efficiency. When the parts, however, suffer from acute disease, the better plan is to support them with a large, soft handkerchief, the

Fig. 606.



Acute Orchitis.

in a threshing machine, one testicle being torn off with a portion of the spermatic cord, and the other completely divested of skin. The greater portion of the flap united by the first intention.

3. *Orchitis*.—Inflammation of the testicle, technically called orchitis, may be acute or chronic, idiopathic or traumatic, primary or consecutive, common or specific. For an account of the syphilitic form of the affection, the reader is referred to the chapter on syphilitic diseases in the first volume.

The acute form of common orchitis is seated principally in the epididymis, and is generally caused by gonorrhœa, the inflammation being transmitted from the urethra along the deferent duct. It may also be occasioned by external violence, great sexual excitement, the effects of cold, and by metastasis, as in mumps. During the existence of gonorrhœa, the most trifling circumstances, as the pressure of the pantaloons, exposure to wet, fatigue, and stimulating injections, may induce the disease. The

epididymis, enlarged to twice or thrice its natural volume, is abnormally firm, and the vaginal tunic is distended with turbid serum, intermixed with flakes of lymph. The testis itself, as seen in fig. 606, is comparatively little increased in size. The part is exquisitely tender, and intolerant of the slightest pressure; the pain is of a dull, heavy, aching, sickening character, and extends upwards in the course of the spermatic cord as far as the loins, where it is often very severe; the scrotum is hot, tense, red, and glistening; high fever is present, frequently accompanied by nausea and vomiting; and, if blood be drawn from the arm, it is usually found to be sized and cupped. The discharge from the urethra is very much diminished, or entirely suspended, and the patient is often annoyed with nocturnal emissions, tinged with blood. In many cases great uneasiness is felt in the groin, abdomen, hip, perineum, and upper part of the thigh. When the epididymitis, as this affection is properly designated, follows upon gonorrhœa, it usually comes on about the end of the third or the beginning of the fourth week of the attack of this disease, although it may occur much earlier, as well as much later. It often affects both glands, either simultaneously or successively. Verneuil has noticed the singular fact that orchitis, especially when accompanied by copious serous effusion into the vaginal tunic, is frequently complicated with inflammation of the throat.

The power of furnishing spermatozoa is often seriously impaired, if not completely destroyed, by the effects of orchitis, or of this disease and of epididymitis, whether the result of gonorrhœa, syphilis, parotitis, or external injury. Hence, if both glands have suffered severely, the individual may be permanently impotent, although it is possible for the organs, ultimately, to regain their natural functions. Fortunately such a condition does not weaken the sexual appetite, or the power of gratifying it; and, as there is always an evacuation of seminal fluid during copulation, the subject of it is never aware of his real situation. It will thus be seen that orchitis is a grave affection, independently of the local and general suffering it occasions.

A testicle retained in the groin may take on inflammation, and thus occasion a train of phenomena closely resembling strangulated hernia, especially when the accident occurs in the adult. The principal signs of distinction are, the absence of the testicle from the corresponding side of the scrotum, the history of the case, the uniform hardness of the swelling, the sickening pain produced on pressure, and the facility with which the bowels are relieved by purgative medicine. The two affections may coexist, and then the tumor will probably be hard at one point, and more or less soft at another. From the close proximity of the testicle to the peritoneum, the inflammation may readily be propagated to that membrane, and in this way a case, which is ordinarily comparatively harmless, may become one of a very dangerous character, occasionally terminating in sloughing and even in death.

The treatment is rigorously antiphlogistic. If the patient is young and plethoric, blood is freely taken from the arm; the bowels are evacuated with senna and Epsom salt, or calomel and jalap; antimony is given in small doses, to keep up nausea;

the recumbent posture is observed; and the scrotum, suspended with a folded handkerchief, is diligently fomented with the lead and opium lotion. Cold applications, seldom agreeable to the patient, are often positively injurious. Blood may sometimes be abstracted advantageously by puncture from the veins of the scrotum, or by leeches from the groin, perineum, or inside of the thighs. Occasionally the animals are applied directly to the inflamed surface.

When the swelling is very large, tense, and painful, a tolerably free incision should be made to afford vent to the pent-up serum, which, whenever the disease is unusually severe, is always present in greater or less quantity, and thus adds greatly to the patient's suffering. In performing the operation, the testicle is grasped at its lower and back part with the left hand, while with the right a narrow, sharp pointed bistoury is plunged perpendicularly into the fluctuating mass above and in front. The want of resistance and the escape of fluid will indicate that the instrument has been carried to the requisite depth. If prompt and decided relief do not follow this proceeding, the knife is reintroduced so as to divide tolerably freely, at one or more points, the albugineous tunic, in order to remove the excessive pressure which it exerts upon the inflamed and sensitive tubular structure beneath. Such an operation, however, will seldom be necessary.

As soon as the disease loses its acute character, as it usually does under the above measures in three or four days, the gums should be gently touched with mercury, and the affected part compressed with a series of strips of adhesive plaster, each about six lines in width, and eight inches in length. The strips are applied as in fig. 607 which explains the process much better than any formal description. The first is placed circularly around the cord, just above the epididymis, as tightly as it can be borne; the second slightly overlaps the first, the third the second, and so on until the whole tumor is enveloped down to its base, when five or six vertical strips complete the dressing.

The patient usually experiences some degree of pain during and immediately after the operation, and should this not subside in an hour or two the compression must be discontinued. The strapping requires to be renewed every twenty-four hours. The advantage of this treatment is that, while it rapidly subdues the disease and promotes the absorption of effused fluids, the patient is able to walk about and attend to business.

4. *Suppuration and Abscess.*—Orchitis does not often pass into suppuration, much less into abscess. When matter is about to form, all the symptoms are suddenly aggravated; rigors come on, often attended with slight delirium; and the part is so painful as to be intolerant of the slightest manipulation and pressure. The pus, generally mixed with seminal fluid, is seldom of a healthy character; and, as it is confined by the albugineous coat, it is always a long time in reaching the surface. The abscess often breaks at several places, thus leaving unhealthy sores, which it is difficult to heal, and which not unfrequently lead to a total disorganization of the tubular structure. Suppuration of the testicle is most common in scrofulous subjects, and in persons affected with tertiary syphilis. The matter is sometimes encysted, as in fig. 608. When pus forms as a consequence of ordinary epididymitis, it is generally situated in the vaginal tunic, and not in the substance of the testicle.

A very remarkable case of abscess in an undescended testicle has been related by Dr. M. M. Eaton, of Peoria, Illinois, in the *Chicago Medical Examiner*. The patient, sixteen years of age, had an exquisitely tender tumor, the size of an orange, in the right iliac region, and died under all the symptoms of acute peritonitis. The testicle,

Fig. 607.



Strapping of the Testicle.

Fig. 608.



Abscess of the Testicle.

increased to ten times its normal bulk, contained a large cavity, which communicated with that of the abdomen, the serous membrane of which was thickly coated with pus.

The treatment consists in an early incision, or, rather, in a delicate puncture, especially when the fluid is situated in the substance of the testicle, the object being to save texture. The retention of pus in the parenchymatous tissue of the gland must be carefully guarded against, as being calculated to do immense harm by disorganizing the tubular structure.

When the matter is allowed to find a spontaneous outlet, the opening is very liable to become the seat of *fungus*, consisting of a mass of tubular substance and unhealthy granulations, as seen in fig. 609, from one of my clinical cases. When the protrusion is small, or of recent standing, it may occasionally be successfully repressed by regular, systematic compression with adhesive strips; or, instead of this, the edges of the opening may be thoroughly pared, and approximated by several points of the twisted suture. In the more severe and intractable cases, the mass must be retrenched with the knife or scissors; this failing, castration must be performed, an operation which is the more proper, because the substance of the testicle is, under such circumstances, generally completely destroyed, as I have repeatedly satisfied myself by dissection.

Fig. 609.



Fungus of the Testicle.

chronic cystitis, and hypertrophy of the prostate gland. The disease is characterized by induration and swelling, which, beginning in the epididymis, where they are always most conspicuous, gradually extend to the body of the testis, forming a tumor four or five times the normal bulk, free from pain, and so slow in its advances as to escape notice until it has produced serious structural changes. This circumstance, together with the irregular shape of the tumor, is sufficiently diagnostic of the nature of the affection. The hypertrophy, which may occur on both sides, is liable to be followed by suppuration of the parenchymatous structure, hydrocele of the vaginal sac, and thickening of the cord. In obstinate cases, a section of the tumor exhibits a dense, fibrous texture, of a reddish or brownish color, interspersed with small cells. It was to this form of the disease that the term *sarcocele* was applied by the older surgeons.

In the treatment of this affection, the indications are to remove any exciting cause that may still be in operation, and to promote the absorption of the effused matter upon the presence of which the hypertrophy depends. To fulfil the latter, the patient is confined to his back, on light diet, and is slightly mercurialized. The best preparations for this purpose are calomel, blue mass, and protiodide of mercury, properly

Fig. 610.



Fibrous Degeneration of the Testicle.

guarded with opium. The bowels are cleared out every other day with castor oil, sulphate of magnesia, or the black draught. Suspension of the scrotum is indispensable; and discutient lotions, tincture of iodine, and local depletion by leeches or punctures are important adjuvants. Ointments are usually hurtful. In some instances, I have derived great benefit from compression, applied as in acute epididymitis. If matter forms, it must be promptly evacuated; fungus is repressed with escharotics and the knife. Steady perseverance in this treatment for six or eight weeks is indispensable to a cure. Castration is unwarrantable, unless malignant action supervenes, which is not probable.

6. *Fibrous, Calcareous, Osseous, and Fatty Degeneration.*—The substance of the testicle, in consequence of protracted inflammation occasionally undergoes the

fibrous degeneration. The change consists in hyperplasia of the interstitial connective tissue, which is gradually converted into white, grayish, or bluish filaments, narrow, dense, resisting, and interlaced in every conceivable manner. The new tissue interferes so much with the nutritive condition of the seminiferous tubes as to occasion, at first, a diminution in their size, and ultimately their entire destruction. When the transformation is complete, the organ is firm, solid, almost incompressible, inelastic, destitute of moisture, and creaking under the knife. Small cysts, containing serous fluid, are occasionally interspersed through it, and specimens are observed in which there are tolerably large cavities filled with whitish, jelly-like matter. The tumor rarely exceeds the volume of a common-sized orange. The vaginal and albugineous tunics often preserve their natural characters. The disease has no tendency to return after removal. The annexed sketch, fig. 610, from a preparation in my collection, conveys a good idea of the peculiar structure of this morbid growth.

The history of the case, the chronic course of the disease, the absence of pain, the freedom from lymphatic involvement, the integrity of the spermatic cord, and the great firmness of the tumor, readily serve to establish the diagnosis between this and other affections of the testicle.

The microscopical characters of fibrous degeneration of the testicle, consequent upon tertiary syphilis, are well illustrated in fig. 611, from a drawing by Dr. Packard. The patient, from whom I removed it, had been laboring under orchitis for nearly three years. The disease was attended with a large fungus and a most copious, fetid discharge; the general health was much undermined, and a painful node existed upon each tibia. The testicle was considerably reduced in size, and consisted mainly of fibrous tissue, interspersed with numerous nuclei, some adherent, others free. A more minute account of syphilitic orchitis will be found in the first volume.

When this disease is fully formed, and the substance of the testicle is completely annihilated, the only suitable remedy is extirpation. In its earlier stages, its progress may sometimes be stayed by sorbefacient applications, aided by occasional leeching and strapping, and by gentle but persistent ptyalism.

Calcification or ossification of the glandular structure of this organ is of very infrequent occurrence. The deposit may take place in any part of the testis, but is most common towards its centre, and is generally accompanied with considerable enlargement. It is often of an earthy rather than a bony nature, being nearly destitute of animal matter, and closely resembling the earthy substance found in the lungs and bronchial glands. Such a formation is exhibited in fig. 612, from a specimen in my possession. The organ, removed from a man, aged thirty, was greatly atrophied, and completely deprived of its natural structure.

The albugineous tunic of the testicle is sometimes ossified, as in a specimen kindly presented to me by Professor McGuire, of Richmond, Virginia, removed after death from a colored man, sixty-five years old. The testicle was much enlarged, the parenchymatous structure was completely annihilated, and the bony shell, several lines in thickness, and laminated in appearance, emitted, when struck, a peculiar sound, similar to that of a dice-box. The man had never complained of any pain.

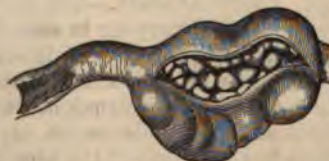
Calcification of the vaginal tunic is an occasional occurrence, but seldom occupies

Fig. 611.



Microscopical Characters of Syphilitic Orchitis.

Fig. 612.



Calcareous Matter in the Testicle.

much extent, and is generally associated with the fibrous and cartilaginous degeneration.

Finally, the testicle occasionally undergoes the *fatty degeneration*, especially when it is habitually compressed, as when it is permanently retained in the groin, or imprisoned in an old rupture. In a case described by Follin, the form of the organ was normal, but its glandular texture was almost entirely replaced by a mass of yellow adipose matter and connective tissue. In other instances, the testicle is enlarged, and interspersed with cysts, some of large size, which are filled with atheromatous material, consisting of fat globules, granular corpuscles, and crystals of cholesterine in great abundance. The walls of the cyst are very thick, covered with granulations, and, in part, calcified. The intervening structure consists of broad bands of compact fibrous tissue, which isolate the cysts from the proper substance of the organ. In a third class of cases, the organ undergoes atrophy, as in the annexed sketch, fig. 613, copied from Curling, which represents the left testicle of a man, forty-six years of age, who died of dropsy, consequent upon disease of the kidney. The organ was reduced to one-fifth its natural size, and its wasted tubular structure was inlaid with fat-globules. Fatty matter was also found beneath the visceral layer of the vaginal tunic.

Fig. 613.



Fatty Degeneration of the Testicle: 1, the Epididymis;
2, Body of the Testicle; 3, Fatty Deposit.

Fig. 614.



Cystic Testicle.

7. *Cystic Disease*.—The testicle, as seen in fig. 614, from Curling, is sometimes the seat of cysts, varying in size from a mustard seed to that of a grape, a marble, or a pigeon's egg, and due to dilatation of, or outgrowth from, the seminal ducts. They are extremely delicate, vascular, gregarious, and filled with fluid, which, in accordance with their dimensions, may be gelatinous, glairy, and discolored by blood, fat-globules, and cholesterine, or, as more rarely happens, thin and watery, and analogous to the serum of the blood. Their number may not exceed six or eight, or there may be hundreds, if not thousands. In old cases, their coats are liable to become firm, opaque, and wrinkled, their contents being thick and glairy, like the white of egg, jelly, starch, or suet. The intermediate substance is connective tissue, at one time sparse and delicate, at another, dense, compact, and solid, in which nodules of cartilage are occasionally imbedded. The disease which is thus formed is of very slow growth, free from pain or constitutional disturbance, and most common between the twentieth and thirty-fifth year. It usually begins in the rete of the testis, the structure of which, together with that of the body of the organ and of the epididymis,

is ultimately entirely destroyed. The tumor may acquire the bulk of a large fist, or even of a foetal head, and is of an oval shape, opaque, heavy to the feel, and less fluctuating than hydrocele, with which it is liable to be confounded. The epididymis retains for a long time its natural outline. The spermatic cord and the glands of the groin are never contaminated, as in encephaloid. The veins of the scrotum are usually very conspicuous. The only remedy for this affection is excision, and it is gratifying to know that the operation, when properly performed, is never followed by relapse.

Cystic disease of the testicle is sometimes associated with *sarcoma*, thus rendering the prognosis, as it respects relapse after operation, very unfavorable. Here, as in the female breast, the interstitial connective tissue is replaced by sarcomatous structure, by which a portion of the tubules is compressed and choked up, while the remainder is dilated into cysts, some of which are filled with fluid, the majority, however, being occupied by pedunculated, dendritic, or papillary masses of the new growth, thereby giving rise to the affection known as proliferous cystic sarcoma. Under the influence of irritation, these tumors are liable to take on new action, increase rapidly, and exhibit the malignant features of ordinary medullary sarcoma in this situation.

Combination of cystic disease with *encephaloid* is also met with, the prognosis being still more unfavorable than in the former neoplasm. It is difficult, when this union exists, to determine whether the carcinomatous matter is superadded to the other during the progress of the case, or whether the two affections had a simultaneous origin; although the latter view appears to me to be the more consistent with modern research. The nature of the disease may be suspected, but cannot always be positively ascertained during life, when the morbid growth advances with unusual rapidity, when it attains an extraordinary bulk, and when there is great enlargement of the subcutaneous veins, with a tendency to disease in the spermatic cord and in the lumbar lymphatic glands.

In another class of cases, also very rare, the cystic disease occurs in union with *enchondroma*, the cartilage presenting itself either in the form of small, whitish nodules, occupying the connective tissue of the gland, or sending irregular, tortuous, or papillary prolongations into the cysts and the lymphatic vessels. However this may be, the adventitious material bears a strong resemblance, both in appearance, structure, and composition, to true hyaline foetal cartilage; its cells, however, are more delicate and more closely clustered together, and there is less uniformity in its color and consistence, especially the latter, which often exhibits no little variety, one portion being, perhaps, quite firm and almost dry, while another is very soft and succulent. The most important diagnostic phenomena are the extraordinary weight and hardness of the tumor, the former of which may reach four or five pounds. Important information in regard to the consistence of the morbid mass may be obtained from the use of the exploring needle. The prognosis does not differ from that of ordinary cystic disease of the testicle.

8. *Tuberculosis*.—Tuberculosis of the testis, in the form of cheesy nodules, is met with chiefly in young subjects of a strumous diathesis. The adventitious deposit, which is more frequent in the epididymis than in the body of the organ, exhibits the same features as in the lungs and lymphatic glands. It occurs in small, isolated masses, from the size of a pea to that of a bean, as in fig. 615, or in the form of infiltration, and, in time, often completely subverts the whole organ, transforming it into a yellowish, curdy, friable, cheese-like substance. The gland is always indurated, more or less altered in shape, and somewhat enlarged. Sometimes the tubercular matter is changed into a hard, cretaceous substance. The disease commences insidiously, is unaccompanied by pain or tenderness on pressure, and often remains stationary for months, if not years. Ultimately, however, the skin becomes adherent, and of a livid hue, the tubercular matter softens, and the resulting abscess bursts, leaving an ill-looking ulcer, which remains fistulous for a long time, discharging a thin, serous, or gleetty pus, often intermixed with semen, and particles of the morbid product.

Fig. 615.



Tuberculosis of the Testicle.

The treatment is conducted in accordance with the same principles as in tubercular disease in general. Due attention is paid to the secretions; the bowels are evacuated by mild aperients; the system is invigorated by tonics and alteratives, as cod-liver oil, quinine, iodide of iron, or Lugol's solution, with bichloride of mercury; and a light, but nutritious, diet is enjoined, with regular exercise in the open air. In short, the aim should be to maintain the general health in as good a state as possible. Any inflammation that may be present is to be combated by leeches, medicated lotions, and rest in the recumbent position. Matter is evacuated by free incisions; fungous growth is repressed by escharotics, or removed with the scissors; and sinuses are treated by astringent injections, or laid freely open with the knife. When the disease is indolent, the part should be pencilled every day with dilute tincture of iodine, or rubbed with some discutient ointment, as that of the biniodide of mercury, diluted with six, eight, or ten times its weight of simple cerate. Compression by means of adhesive strips, applied in the same manner as in epididymitis, often tends to promote the absorption of the adventitious matter, and to hasten the resolution of the tumor. When the organ is completely subverted in its structure, and traversed with sinuses, the proper remedy, of course, is excision.

9. *Encephaloid*.—The most common malignant disease of the testicle is encephaloid, soft carcinoma, or fungus hematodes, from which no period of life is exempt. It was formerly supposed that young persons were most frequently affected with it, but experience has shown this opinion to be erroneous. Of 51 cases collected by Mr. Ludlow, of London, 39 occurred from the twentieth to the fiftieth year, 5 before the fifth year, 1 from the fifteenth to the twentieth year, and 6 from the fiftieth to the seventieth year. Most of the cases in my own practice occurred in young adults. I have seen several instances of encephaloid of the testicle in which this organ was retained in the groin; and a case has been reported by Mr. Johnson, of London, in which the malady affected a testicle that had never left the cavity of the abdomen. It has been thought, and not without reason, that a retained testicle is, relatively speaking, more liable to suffer in this wise than one in the scrotum.

Encephaloid rarely occurs on both sides. The disease, which is always rapid in its progress, and is often associated with cysts, enchondroma, and sarcoma, begins in the body of the testis, from which it soon spreads to the epididymis, then to the cord, and finally to the lumbar lymphatic glands. The tumor is of a pyriform figure, being larger below than above, and somewhat flattened in front; knobby and irregular, pulpy and elastic, heavy, opaque, and devoid of fluctuation. The weight is occasionally enormous, as in a case recorded by Boyer, where it reached nine pounds. The volume ordinarily does not exceed a large fist or foetal head. Sometimes the testicle remains sound, but is completely encased in medullary matter. The disease is at first unattended with pain; but, as it advances, the suffering often becomes very great. In the latter stages of the complaint, the countenance exhibits the greenish-yellow hue so characteristic of the carcinomatous cachexia; and the tumor, red on the surface, and traversed by large subcutaneous veins, protrudes in its well-known form of a bleeding, brain-like fungus. Under the sloughing, discharge, and pain, of which the ulcer is the seat, and the consequent hectic irritation, the patient rapidly sinks. Death has been known to occur within four months from the first appearance of the disease; but the average duration of life is nearly two years. The prognosis is unfavorable; therapeutic measures are unavailing; and ablation, however early performed, is nearly always speedily followed by a recurrence of the disease. Cases of immunity from a relapse of five, nine, ten, eleven, and twelve years have been reported, respectively, by Baring, Meade, Curling, Cooper, and Hawkins. Such cases are, of course, exceptional, and, although exceedingly interesting in a practical point of view, cannot be regarded as examples for general operative interference.

The remaining varieties of carcinoma of the testicle do not demand any special notice. The occurrence of scirrhus is exceedingly problematical, modern histological research having failed to confirm the observations of the earlier pathologists. Colloid is unknown, while melanosis has occasionally been met with.

10. *Sarcoma*.—Of the malignant diseases of the testicle, next to encephaloid, the most common is medullary sarcoma, and their distinction is only possible with the aid of the microscope. In 1870, I extirpated the left testicle of a healthy, robust man, thirty-two years of age, which had a uniform, full, firm, and dense feel, without elasticity or apparent fluctuation at any point. There was not the slightest inequality of its surface; the scrotal coverings were sound and unadherent; the

superficial veins were normal; there was no evident involvement of the lymphatic glands; and the sac of the vaginal tunic was free from fluid; but the veins of the cord were enlarged and tortuous. After removal, the tumor, which had made its appearance nine months previously, and was latterly painful on pressure at its upper limits, was found to be of an ovoidal figure, somewhat flattened from side to side, and nearly nine inches in its transverse, by eleven inches in its vertical, circumference, with a weight of ten ounces. The cord and epididymis were uninvolved, and the albugineous tunic perfect. On section, the surfaces displayed a homogeneous, moderately firm structure, of a delicate rosaceous tint, with here and there points of linear injection, easily broken down on pressure, and exuding a milky juice on scraping. Its microscopic character was that of small round-celled sarcoma. At the present date, two years subsequent to the operation, there has been no return of the disease.

Sarcoma does not always pursue the flattering course as in the case just narrated. On the contrary, when it arises in the epididymis, or when it perforates the albugineous coat of the testicle, it soon invades the cord and lumbar glands, and infects distant organs. These eminently malignant features are particularly evident when the disease is combined with carcinoma, in which event the organ attains huge proportions, cases having been observed in which it weighed fourteen and even fifteen pounds. Anatomically such tumors consist of a soft, spindle-celled stroma, containing alveoli filled with epithelial elements.

11. *Enchondroma*.—Of the different glands, next to the parotid, the testicle seems to be the favorite seat of the cartilaginous tumor, where, as already stated, it is usually combined with cysts, sarcoma, or encephaloid, although pure forms, of a hyaline constitution, and rarely exceeding the volume of a hen's egg, are met with. In the majority, if not all, of the instances, indeed, of association of cysts with enchondroma, there is every reason to believe that the latter is the primary affection, the former being due to partial occlusion and ectasy of the seminiferous tubules, through the compression exerted upon them by the new material, developed at the expense of the intertubular connective tissue. Arising usually in the rete of the organ, the cartilaginous tumor very frequently shoots prolongations into the lymphatic vessels, which exist in great numbers between the tubules, thereby giving the mass a peculiar tortuous and ramified appearance. The diagnosis is based upon the weight, hardness, and slow progress of the growth. The prognosis is commonly favorable. The general dissemination of enchondroma by means of the lymphatic vessels is well shown by a remarkable case of unmixed tumor, removed by Paget from a man, thirty-seven years of age, death having occurred from lung complications a few weeks subsequently. Two enlarged, varicose lymphatics, filled with cartilage, were traced along the spermatic vessels, from one of which a small mass projected into the vena cava; while the lungs were dotted, and the larger branches of the pulmonary artery infiltrated, with similar deposits. If, after having existed for several years as a painless, circumscribed swelling, such a tumor suddenly, rapidly, and painfully enlarges, the development of sarcoma may be suspected.

12. *Myomatous and other Tumors*.—Among the rarer neoplasms of the testicles are muscular tumors, formed principally of striated fibres, examples of which have been reported by Rokitsky, Rindfleisch, and Billroth. Their presence may be suspected by their congenital origin, firm, elastic consistence, and small volume. *Hydatids* are so uncommon as not to demand any special notice. A few instances have been observed, chiefly among the inhabitants of the tropics, in which this organ contained a cyst, occupied by the *filaria medinensis*, or guinea worm. *Dermoid cysts* are treated of in the section on affections of the scrotum.

13. *Atrophy*.—Atrophy of the testicle may be induced by a great variety of causes, as excessive venery, masturbation, external violence, wounds, mechanical pressure from tumors, effused fluids, or enlarged veins, obliteration of the spermatic artery, lesion of the cerebellum, and the inordinate use of iodine, alcohol, and narcotics. Occasionally it follows neuralgia and acute orchitis. The wasting, which is usually very gradual, is most common in young subjects, and often reduces the gland to a soft, pulpy structure, less than one-third the natural volume. The treatment is restricted, in great measure, to the removal of the exciting cause. Restoration of the normal bulk is hardly possible.

14. *Neuralgia*.—Neuralgia of the testis is chiefly observed in young subjects, of a nervous, irritable temperament, and generally arises without any obvious cause, although in many instances it is referred to external violence, stricture of the urethra,

or disease of the prostate gland, bladder, or rectum. In most of the cases that have fallen under my notice, it was connected with dyspepsia and neuralgia of other organs. Masturbation, venereal excesses, and varicocele occasionally induce the disease. In some cases it is of a distinctly malarious origin. It is characterized by constant uneasiness, excessive morbid sensibility, and violent darting pain, which is frequently paroxysmal, is aggravated by the slightest motion and pressure, and always extends to the neighboring parts, particularly the spermatic cord, back, and groin. Occasionally the pain is of a dull, heavy, aching nature, circumscribed instead of diffused, and relieved rather than increased by exercise. During the height of the suffering the testicle is closely retracted, and intolerant of the slightest manipulation. In protracted cases, the general health is always materially impaired; the digestive organs are disordered; and the patient is a prey to despondency and unpleasant foreboding. There is no swelling of the testicle, and generally no perceptible alteration in its structure. Occasionally, however, it is very much wasted, if not entirely destroyed. The cord is usually sound.

The treatment is similar to that of neuralgia in other parts of the body. After a preliminary course of moderate purgation, which should never be neglected, much may be expected from a combination of quinine, aconite, strychnia, and arsenic, as recommended in a former chapter. Low diet, mercury, and bloodletting generally aggravate the complaint. Stramonium is sometimes efficacious. The best local remedies are belladonna, aconite, and veratria, either in solution or in the form of ointment, rubbed on the scrotum and groin twice in the twenty-four hours. Temporary relief often follows the application of warm water. In some instances I have derived signal benefit from the application of a small blister to the groin, succeeded by the endermic use of sulphate of morphia. The organ must be properly suspended and protected from pressure. Castration can never be justifiable, not even when there is hopeless atrophy, inasmuch as the neuralgia would be certain to locate itself upon some other structure.

15. *Castration.*—Excision of the testicle, rendered necessary on account of different diseases, is generally a very simple operation. If the integument is not involved, a single incision will suffice, extending from the upper to the lower part of the tumor, along its anterior surface; otherwise it must be of an elliptical form. Great care, however, must be taken not to remove too much substance, as will be likely to be done, if proper allowance is not made for shrinkage. The tumor during this stage of the operation is supported with the left hand, applied to its posterior surface. The next step consists in detaching the spermatic cord from the surrounding parts, and cutting it off just above the tumor, as in fig. 616; but before this is done

Fig. 616.



Excision of the Testicle.

it is seized with a double hook, and drawn down, until its vessels are secured. A long, stout ligature being now passed through its connective tissue, but not tied, so that, in the event of secondary hemorrhage, the cord may at any moment be pulled out, the instrument is removed, and the organ rapidly detached from above downwards. In doing this, care must be taken not to wound the sound testicle, or to divide the scrotal septum. When the cord is diseased, it may be necessary to extend the dissection into the inguinal canal, and to include the whole mass in a strong thread previously to its division. In a case of incipient encephaloid of the testis upon which I operated in 1863, with the assistance of Dr. F. F. Maury, I included the entire cord, although perfectly sound, in a wire ligature left permanently in the groin. No unpleasant effects whatever followed. In a case in the practice of Mr. Chandler, of London, in 1807, in which the whole cord was tied by a single ligature,

tetanus set in on the ninth day, and terminated fatally in forty-eight hours. From three to six little arteries will generally require ligation, and it will be well not to

slight any vessel of this kind, however insignificant, otherwise secondary hemorrhage will almost be inevitable. The edges of the wound should be approximated with metallic sutures, but not until the skin has become thoroughly contracted, which will seldom be under five or six hours. To prevent hemorrhage, and promote cicatrization, the parts should be well supported, and kept constantly covered with a small bladder partially filled with pounded ice. Any tendency that may occur to inversion of the edges of the wound should be counteracted by the use of adhesive strips.

Instead of employing the ordinary dressings, I have on several occasions brought the deep portions of the wound closely together by means of several twisted sutures, by transfixing the flaps near their points of junction, and then throwing the ligatures around the pins over the edges of the wound. This procedure not only greatly promotes union by the first intention, but is one of the best safeguards against the occurrence of hemorrhage.

When disease of the testicle, requiring removal, is associated with scrotal hernia, the parts should be reduced previously to the operation, which should then be conducted in the usual manner, care being taken not to wound the sac.

When a testicle, the subject of malignant disease, is situated in the groin, safe removal can only be effected by the most patient and cautious dissection. Unless unusual care be taken, there will be great danger of wounding the peritoneum, if not also the bowel and omentum, especially if the affection coexists with inguinal hernia, and of thus lighting up fatal inflammation. The principal incision should be carried in the same direction as in the operation for the relief of strangulated hernia, only somewhat higher up, and free use made of the grooved director in dividing the superimposed structures. As the diagnosis is generally obscure, the first step should be of an exploratory character. As the cord requires to be divided unusually high up, the securest plan is to include it, vessels and all, in a wire ligature left permanently in the parts.

Ordinary castration is commonly a perfectly safe procedure. I have myself never met with any serious accident. The chief sources of danger are secondary hemorrhage, erysipelas, pyemia, and peritonitis. The latter affection will be most likely to occur when the dissection is extended very high up into the inguinal canal. Secondary hemorrhage is a great evil after this operation, as, from the infiltrated condition of the connective tissue, it is not only very difficult to tie the bleeding vessels, but the disturbance thus occasioned may lead to copious and troublesome suppuration. A considerable number of cases of successful self-castration have been recorded.

16. *Bandages for the Testicle.*—Various contrivances may be employed for supporting a diseased testicle, rest being of great importance in all affections of this

Fig. 617.



Gum-elastic Suspensory.

Fig. 618.



Mayor's Suspensory Apparatus.

organ, as well as in those of the vaginal tunic, the scrotum, and the spermatic cord. The article usually preferred is the ordinary gum-elastic bag, represented in fig. 617, or a bag made of knit silk, both of which have the advantage at once of softness, lightness, and efficiency. When the parts, however, suffer from acute disease, the better plan is to support them with a large, soft handkerchief, the

centre, folded cornerwise, being applied to the scrotum, and the ends attached to a circular belly-band. The same object may be attained by the use of Mayor's *suspensory triangle*, exhibited in fig. 618. A band being fastened around the abdomen, as in the preceding case, the base of a piece of muslin, cut in the form of a triangle, is applied to the root of the scrotum, while the tails, brought up in front, are passed around the belly-band from before backwards, and tied in front into a double slip-knot. The apex of the triangle is next carried around the band in the opposite direction, and pinned to the transverse portion of the tails. In many cases, the requisite support may readily be afforded by a broad strip of muslin, the ends of which, spread with adhesive plaster, are carried obliquely upwards, over the abdomen, in the direction of the spinous processes of the iliac bones.

SECT. II.—AFFECTIONS OF THE VAGINAL TUNIC.

The principal affections of the vaginal tunic of the testicle are acute inflammation, hydrocele and hematocele.

ACUTE INFLAMMATION.

Acute inflammation of this membrane is exceedingly frequent, but as it is generally associated with orchitis, it is often difficult to detect its true character. The most common cause of the disease is repulsion of gonorrhœa, but it may also arise from external injury, as a blow, or wound, the application of nitrate of silver, or the injection of an irritating fluid, as iodine or port wine. A tight stricture of the urethra may likewise give rise to it.

The attack, however induced, is usually rapidly followed by an effusion of serum and lymph, the latter of which is either commingled with the former, or it adheres closely to the inner surface of the affected membrane, occasionally presenting a honeycomb-like appearance, as is sometimes noticed in the pericardium. The quantity of serum is generally small. When the inflammation is intense, as, for example, after the injection of a hydrocele, the fluid is often of a reddish color, from the presence of hematin.

The most prominent local symptoms are, more or less swelling of the testicle, severe pain, of a tensive, aching, or throbbing character, and exquisite tenderness on pressure, with a distressing sense of weight. The part feels hard, and the scrotum is of a reddish color. With a little care, distinct fluctuation may be detected, especially if the effusion is at all considerable. The patient is feverish and restless. The disease, if not speedily arrested, may terminate in suppuration.

The treatment must be strictly antiphlogistic. Recumbency, depletion, and abstinence from food are of paramount importance. The testicle is carefully suspended, and kept constantly wet with a strong solution of lead and opium. If the morbid action is unusually severe, leeches may be applied. The excessive pain and tension are most effectually relieved by an early incision, in order to afford free vent to the pent-up fluid.

HYDROCELE.

Hydrocele is an accumulation of water in the vaginal tunic of the testicle, or in a serous cyst of the spermatic cord, between this gland and the abdominal ring. A similar affection occasionally exists in a hernial sac. It is most common in adults, but may occur at any period of life; sometimes, indeed, it is congenital, and, on the other hand, it is occasionally met with at a very advanced age. Thus, in a case which I attended with Dr. Wilson Jewell, the patient was ninety-one years old, and the tumor contained not less than twenty-four ounces of limpid fluid. The affection, which sometimes forms very rapidly, usually arises without any obvious cause, and presents itself in several varieties of form, as the simple and the encysted.

Hydrocele of the Vaginal Tunic.—Hydrocele of the vaginal tunic may be single or double, although the latter is infrequent, especially in this country. It appears, however, to be sufficiently common in the East Indies; for of 1000 cases of the disease, treated at the Native Hospital at Calcutta, it was double in 370. It occurs with nearly equal frequency on both sides.

The fluid, varying in quantity from ten to twenty ounces, is generally thin and

limpid, but in old cases, or when there is disease of the testicle, epididymis, or serous membrane, it is apt to be thick and of a yellowish, amber, or citron color. Sometimes it is red, brownish, or slightly greenish; and in several instances under my observation it was of a chocolate hue, or of the color of black coffee, probably from the presence of hematin, purulent, fibrinous, or intermixed with particles of cholesterine. It is free from odor, saline in taste, and coagulable by heat, alcohol, and the dilute acids; circumstances which show its affinity with the serum of the blood from which it is derived. Cases have been noticed in which it had a lactescent appearance. Spermatozoa are also occasionally found in it, but much oftener in encysted than in ordinary hydrocele.

The quantity of fluid in hydrocele is subject to much diversity; in this country it rarely, on an average, exceeds sixteen, eighteen, or twenty ounces. Cases, however, occur, in which it is much greater. Thus, Dr. Jones, physician to Franklin and Washington, has recorded an instance, in his work on surgery, of two gallons; and Professor May has communicated to me the particulars of the case of a negro, sixty years of age, of seventy-two ounces, the tumor measuring nearly twelve inches in length, by twenty-three inches in circumference. Gibbon, the historian, had a hydrocele which contained a gallon and a half of fluid. The largest accumulations of this kind generally occur in the inhabitants of tropical climates, particularly in those of the East and West Indies.

The vaginal tunic in this affection is commonly unaltered; but in old cases it is sometimes very hard, opaque, thickened, fibrous, cartilaginous, or even partially calcified. Instances are recorded in which its inner surface was studded with fine sandy matter, evidently the result of former inflammation. The cavity of the vaginal tunic is occasionally intersected by fibrinous bands, or even divided into distinct compartments, forming a sort of multilocular tumor; and examples are observed in which it contains serous cysts, hydatids, or cartilaginous concretions. The albuginous coat is seldom changed. The same is generally the case with the testicle; but this organ is sometimes enlarged and preternaturally firm, and the disease is then termed *hydro-sarcocele*. Fig. 619, from a preparation in my collection, exhibits the appearance of the parts in the more common forms of hydrocele. When the quantity of liquid is very great, its pressure upon the testicle, especially if long-continued, may cause more or less atrophy, if not complete destruction of the parenchymatous structure.

This variety of hydrocele forms as a slow, chronic swelling, with little or no pain, and no discoloration of the skin; elastic; fluctuating; smooth on the surface; movable, but unaffected by pressure and position; translucent under transmitted light; of an ovoidal or pyriform figure; gradually ascending from the lower part of the scrotum upwards; and varying in size from a small fist to that of a fetal head. The testicle lies at the posterior part of the tumor, towards its inferior third, and the spermatic cord may generally be easily felt in its natural situation. The swelling is sometimes contracted at the middle so as to give it an hour-glass appearance, and not unfrequently it assumes an elongated pyramidal form, being larger above than below. In old cases, or where the accumulation is very considerable, amounting to fifteen or twenty ounces, it is very hard, tense, and devoid both of fluctuation and translucency. The testicle is occasionally situated in front, and in a number of instances I have met with it at the bottom of the tumor. Not long ago I treated a case in a youth of fourteen years, in which the organ was suspended at the top of the fluid.

Fig. 619.



Hydrocele of Vaginal Tunic.

The *diagnosis* is determined by the history of the tumor, by its gradual increase from below upwards, by the absence of pain, by the sickening sensation experienced on making pressure in the situation of the testicle, by the want of impulse on coughing, and by the peculiar shape of the swelling. By darkening the room, and then holding a candle opposite the tumor, at the same time that one hand is placed in front and the other behind it, a certain degree of translucency is generally perceived. Instead of conducting the examination in this wise, an instrument called the photoscope may be used, without the trouble of excluding the light from the patient's apartment. It consists of a tin-tube, blackened on the inside, about seven inches in length by one inch and a quarter in diameter at the larger end. The other extremity, which tapers down to nine lines, is furnished with a wooden eye-piece. The translucency will be rendered most distinct by placing the hands in front and behind the tumor, as in the ordinary exploration.

In hernia, with which this affection is most liable to be confounded, the swelling begins at the abdominal ring and gradually descends; the spermatic cord is situated at the back part, and the testicle at the bottom; there is a distinct impulse on coughing; and the contents disappear on pressure, or on assuming the recumbent position. Moreover, in scrotal hernia there is generally an unusual fullness in the groin, increased on coughing, with an appearance of active motion, owing to the distension of the bowel. In hydrocele, as well as in sarcocele, the groin, especially in the milder cases, retains its natural aspect and feel, and the tumor may be thrown about more, being easily pushed upwards, downwards, or laterally; a procedure which is either very difficult, or quite impracticable, in scrotal hernia, on account of the angle formed by the protruded parts.

It is hardly possible that a hydrocele should be confounded with a varicocele. Hydrocele occurs at all periods of life; varicocele chiefly in young persons soon after the age of puberty. In hydrocele the tumor is tense, fluctuating, and elastic; in varicocele, soft, doughy, and vermiform in feel. In the former, the swelling is fixed or stationary; in the latter, it may be made to disappear by lifting up the scrotum, and pressing the blood out of the enlarged varicose veins.

In sarcocele, cystic disease, and encephaloid of the testicle, the tumor feels heavier than in hydrocele, its shape is more irregular, the surface is less smooth, there is an entire absence of translucency, and the gland is deprived of its natural sensibility. In all obscure cases, an exploring needle, carefully inserted, will reveal the true nature of the affection.

Treatment.—Hydrocele is unattended with danger, but as it incommodes by its weight and bulk, the patient is in time induced to apply for relief. The disease occasionally disappears spontaneously during the treatment of other affections; in some instances a cure is effected by the accidental rupture of the sac by external violence; and sometimes the fluid is removed by the use of blisters, tincture of iodine, spirit of camphor, pustulation with tartar emetic, and lotions of hydrochlorate of ammonia. When the tumor has attained a certain bulk, nothing short of tapping is found to answer, and this operation may be performed either with a view to a palliative or a radical effect.

The palliative treatment is indicated chiefly when the patient is very old and feeble, or so timid as to be unwilling to submit to the radical operation; when the tumor is very bulky; or, lastly, when the disease is complicated with sarcocele, enlargement of the spermatic cord, scrotal hernia, or stricture of the urethra. It consists in evacuating the fluid from time to time with a lancet, bistoury, or trocar, the patient being erect, seated in a chair, or placed in the recumbent posture. The tumor, rendered tense by grasping it behind with the left hand, is punctured at its anterior part, just below the middle, by inclining the instrument obliquely upwards and backwards, in order to avoid injury of the testis. If a trocar be used, the perforator is now withdrawn, and the canula pushed into the sac, where it is retained until all the serum has escaped. When the operation, which is exceedingly simple and easy of execution, is over, the wound is either left uncovered, or it is closed with a piece of adhesive plaster, and the scrotum supported with a suspensory bag. Undue excitement is avoided by observing for a few days light diet and the recumbent posture. If this precaution be neglected, acute inflammation of the vaginal tunic may arise, followed by suppuration, abscess, or sloughing. The operation usually requires to be repeated in four, six, or eight months. The an-

nexed cut, fig. 620, exhibits the manner of grasping and piercing the tumor.

The vaginal tunic may also be emptied by *acupuncture*, performed with a cataract needle, introduced at four or five different points of the tumor. A slight oozing, or a thin, thread-like stream occasionally follows the withdrawal of the instrument; but, in general, the serum, instead of escaping externally, gradually infiltrates the cellular tissue of the scrotum, whence it is removed in two or three days by absorption. Acupuncture is applicable chiefly to recent hydrocele, and is followed less quickly by reaccumulation than after the fluid has been evacuated by the trocar or knife.

A hydrocele has sometimes been cured by the accidental rupture of its sac. A case came under my observation many years ago in which such an effect followed upon a severe blow of the tumor against the pommel of the saddle during a ride on horseback. A Hindoo had long been troubled with an immense hydrocele, which was permanently obliterated by the inflammation caused by a punctured bayonet wound. Dr. Lente has reported the particulars of a case in which a hydrocele of considerable size was succeeded by a large hemothorax by the accidental rupture of the vaginal tunic.

For the radical cure of hydrocele, the principal operations are incision, excision, cauterization, the seton, and injection. Of these, the first three are nearly obsolete, and will, therefore, require but little notice. Incision, the most ancient method of all, consists in laying the sac freely open with a knife, and dressing the wound simply with lint, or some irritating substance. Acute inflammation soon succeeds, followed by suppuration, and the part finally heals by the granulating process. Incision is objectionable in common cases, but may be advantageously resorted to when the tumor is multilocular, or when it contains cysts, hydatids, or cartilaginous concretions. Excision, which is also of considerable antiquity, was revived, in 1755, by Douglas, of England, and is performed by cutting away a portion of the serous sac with a pair of scissors, the cord and testis being left intact. The after-treatment is the same as in incision. A modification of this operation, proposed by Mr. Kinder Wood, consists in opening the tumor with a broad-shouldered lancet, and snipping off a small piece of the vaginal tunic, previously hooked up with a tenaculum. The puncture is closed with adhesive plaster. The operation, however, rarely succeeds. The treatment by caustic was much employed during the last century, but is now entirely exploded. The caustic was applied in the same manner as for making an issue; the sloughing extended to the serous membrane, which, after evacuation of the fluid, gradually contracted like an ordinary abscess, and was ultimately obliterated by adhesion or granulation.

The use of the *seton* for the radical cure of hydrocele originated with the Arabians, and was much in vogue in the fourteenth century. Pott strongly recommended it, and has given a minute description of the mode of introducing it. The operation, which I prefer to every other, both on account of its simplicity, its freedom from danger, and its never-failing certainty, is performed in the same manner as in the method by injection, except that the puncture is made a little lower down. After all the water has escaped, the canula is pushed on towards the superior part of the scrotum, where a counter-aperture is made by the reintroduction of the perforator. The instrument being withdrawn, a piece of braid, or narrow strip of muslin, is passed through the canula by means of an eyed probe. The operation is finished by removing the canula, and tying the ends of the seton loosely in front of the scrotum. Sometimes a few shreds, or a piece of thin twine, introduced with a curved needle, will answer the purpose. Whatever substance be selected, the proper plan is to let it remain from twenty-four to forty-eight hours, or until the scrotum is quite hard, and at least one-fourth as large as before the operation. The part should meanwhile be well suspended, and the patient kept on his back. For the first few days after

Fig. 620.



Operation of Tapping a Hydrocele, the Trocar Entering the Tumor.

the removal of the seton, fomentations of acetate of lead and opium are the most eligible; and these may be gradually, but cautiously, succeeded by spirituous lotions, dilute tincture of iodine, or mercurial ointment. The cure is usually completed within a fortnight. I have performed this operation many times, and have never known it to be productive of any ill effects.

The treatment by *injection* is alluded to by Celsus, but the credit of introducing it into general practice is due to Sir James Earle, who published a treatise on it in 1791. The apparatus required for the operation is a rounded trocar and canula, and a brass syringe, or gum-elastic bag, furnished with a nozzle and stopcock. Almost any kind of fluid may be used, as lime-water, milk, simple water, dilute alcohol, wine, spirit of camphor, and solutions of alum, zinc, nitre, chloride of sodium, tannic acid, nitrate of silver, or corrosive sublimate. Earle was in the habit of employing port wine and water, in the proportion of two-thirds of the former to one of the latter. At present, the favorite injection is tincture of iodine, either pure or diluted with three to five parts of water.

In performing the operation, the patient sits, stands, or lies, as may be most convenient, the hydrocele being punctured in the same manner as in the palliative method. After the water, however, has been evacuated, the canula is pushed in as far as possible, and the vaginal tunic carefully nipped around it with the thumb and forefinger. The tube of the syringe is then applied to the orifice of the canula, and the stimulating liquid is gradually injected until the sac is slightly distended. It is rarely necessary to throw in more than two or three ounces, especially if the fluid is brought in contact with every part of the surface of the serous sac, as it readily may be by compressing the scrotum with the hand. In general, the injection is retained from two to five minutes, or until the patient complains of a slight sickening sensation, and of pain in the part and in the spermatic cord, when the liquid is squeezed out, and the canula withdrawn. The wound may be let alone, or be closed with a strip of adhesive plaster. When pure tincture of iodine is used, from two to three drachms are injected, and permitted to remain permanently in the sac, from which it disappears by absorption. Usually, however, it is best to throw in several ounces of a weak solution, and to remove it as soon as it causes pain or other inconvenience. When the tumor is very large, instead of injecting it at once, it should be tapped with a trocar, and the radical treatment deferred until the fluid has reaccumulated in smaller quantity. In case the hydrocele is double, it would be improper to operate upon both sides at the same time.

The treatment, after injection, is strictly antiphlogistic; the part is carefully watched, and undue action promptly met by warm saturnine fomentations, purgatives, and nauseants. If the inflammation is likely to prove insufficient, the scrotum may be kneaded with the hand, or the patient may walk about the apartment. Should the operation fail, it may be repeated as soon as there is a moderate reaccumulation of fluid. When the injection escapes into the cellular substance, the scrotum must be freely incised, and, after the fluid is pressed out, it is covered with warm fomentations.

The chief objections to this method of treatment are, first, its liability to occasional failure; secondly, the escape of the injection into the cellular tissue of the scrotum; thirdly, the difficulty of regulating the amount of inflammation; and, fourthly, the occurrence of extensive suppuration, abscess, and even sloughing. In a case which I witnessed in a young, robust mechanic, a patient of Dr. McIlwain, the injection, consisting of port wine and water, was followed by tetanus and death. The vaginal tunic was considerably thickened, and contained several ounces of sero-sanguinolent fluid, intermixed with pus and lymph; but no adhesions had taken place between the opposite sides. The patient was twenty-six years of age, and the disease made its appearance on the eighth day after the operation.

During the last ten years, I have effected a number of rapid and excellent cures of hydrocele, both in adults and children, by laying open the vaginal tunic with a small incision, and, after all the fluid had been discharged, *mopping* the sac freely with equal parts of tincture of iodine and alcohol, or iodine variously diluted. In no instance have any unpleasant symptoms followed this procedure.

Excellent and rapid cures of this complaint have occasionally been effected by drawing off the water, and then blowing into the empty sac a small quantity of red oxide of mercury, nitrate of silver, sulphate of copper, or acetate of zinc, reduced to a fine powder, and permanently retained. Mr. Harvey, of Bristol, England, has

generally succeeded in accomplishing the object by enveloping the scrotum for a few hours in a warm vinegar poultice. Pleindoux, of Nismes, has been equally successful with strong alcoholic fomentations. I have no experience with these expedients.

Hydrocele has sometimes been treated by *electro-puncture*. The operation, which originated with Dr. Pechioli, of Italy, is performed by introducing at different points of the tumor two slender acupuncture needles, four inches in length, and connecting one to the positive and the other to the negative pole of a Daniell's constant battery. The action may be maintained from five to forty minutes. The process, which is not free from pain, is best adapted to recent cases, and is occasionally followed by a cure. In general, however, it requires to be several times repeated at intervals of two or three days.

In old hydroceles, of large size, the best plan always, according to my experience, is to draw off the water several weeks before an operation is performed for the radical cure of the complaint. The shrinkage which takes place after the operation greatly diminishes the size of the tumor, and the chance of speedy relief, attended with comparatively little suffering, is thus greatly increased.

Congenital Hydrocele.—In congenital hydrocele, the original communication between the peritoneum and the vaginal tunic continues open instead of being obliterated, as it is in the ordinary form of the complaint; and, hence, the fluid passes readily from one of these cavities into the other, as the bowel does in congenital hernia. The intervening canal is seldom larger than a goose-quill. The tumor, which is smooth, translucent, and fluctuating, and which usually appears soon after birth, is prolonged into the groin, and receives an impulse on coughing; it is larger in the erect than in the recumbent posture, and by gentle pressure its contents may be gradually forced into the abdomen, the testicle remaining in the scrotum. The indication is, first, to obliterate the neck of the sac, so as to cut off the communication with the peritoneal cavity; and, secondly, to encourage the removal of the fluid by absorption. This may usually be fulfilled by the constant pressure of a spring-truss, and the use of discutient lotions, iodine, or acupuncture. In adults, or in obstinate cases, the ordinary treatment may be required. The seton and injection, before closure of the intervening canal, are liable to be followed by inflammation, which, extending to the peritoneum, might endanger life.

Encysted Hydrocele.—A hydrocele of the testis may be encysted, as in fig. 621, the fluid being contained in an adventitious sac, distinct from the vaginal tunic, and composed of a thin, delicate serous membrane. The tumor is small, perhaps not larger than a common marble, tense and elastic, with little or no fluctuation and translucency, and filled with a limpid, colorless, almost uncoagulable fluid. The testicle is in front or at the side, seldom at the back, as in simple hydrocele; and the disease is commonly developed beneath the serous investment of the epididymis, although it may arise also between the vaginal and albuginous coats of the gland. When the tumor consists of two cysts, it has sometimes a lobulated appearance.

This form of hydrocele very frequently contains spermatozoa, on which account it is termed by some writers *spermatocele*, caused, as Mr. Curling, by whom it has been so well described, conjectures, by the rupture of some of the seminiferous tubes, and the escape of their contents into the sac of the tumor. A more plausible theory, however, is that the cyst is an outgrowth from one of the tubes of the epididymis, with which a distinct communication has been demonstrated by Luschka and other observers. When no such direct communication between a tube and the cyst can be traced, it is, nevertheless, highly probable that it originated in this way, and subsequently lost its connections. The spermatozoa sometimes exist sparingly, at other times in great numbers, and they have been found at various periods of life, from the thirtieth to the seventy-fifth year, in cysts of all sizes, from that of a filbert up. When very numerous, they impart a lactescent or opaline appearance to the fluid in which they are contained, and when the fluid has remained for a while in a glass vessel, they subside to the bottom, leaving

Fig. 621.



Encysted Hydrocele.

the lower portion more opaque than the upper. What is remarkable is that these bodies are often as lively as in fresh semen.

The encysted hydrocele seldom requires interference; should it do so, it may readily be removed by a seton, consisting of a single cord of saddler's silk.

Hydrocele in Childhood.—Hydrocele occurs in children. The tumor is remarkably translucent, soft, fluctuating, and seldom larger than a hen's egg. The water often disappears spontaneously; and, when treatment is required, the means should always be much milder than in hydrocele of the adult. A cure may frequently be effected in a few days by pencilling the scrotum with iodine, or by the use of some discutient lotion, as hydrochlorate of ammonia, alum, acetate of lead, or a combination of equal parts of alcohol and camphorated spirit,

with the addition of a small quantity of Goulard's extract. In several cases, I have succeeded perfectly by letting out the water with a lancet, and then strapping the part with adhesive plaster, as in orchitis. When these means fail, acupuncture may be resorted to; or the tumor may be traversed with a filiform seton, consisting of a simple, delicate thread, wet with tincture of iodine, and retained from twelve to twenty-four hours; not longer, lest undue inflammation should ensue.

It is impossible, in the treatment of hydrocele in children, to be too cautious. Such is the excessive sensibility of the vaginal tunic at this period of life that the mildest operation is sometimes followed by a frightful amount of inflammation, endangering both part and system.

Hernial Hydrocele.—The sac of an old scrotal hernia, after the obliteration of its neck, sometimes becomes dropsical, constituting what is termed *oscheo-hydrocele*. The tumor is of considerable bulk, pyramidal, fluctuating, translucent, and occupied by a viscid, amber-colored fluid. The diagnosis is easy, and the treatment is the same as in ordinary hydrocele. Occasionally, the two diseases coexist, as is shown in the adjoining



Hydrocele associated with Hernia.

sketch, fig. 622, where the sac of an inguinal hernia is situated immediately above a small hydrocele of the vaginal tunic.

HEMATOCELE.

By a hematocele, exhibited in fig. 623, is understood a collection of blood in the vaginal tunic of the testicle. The swelling is either globular or pyramidal, being larger below than above, opaque, tense, heavy, and nearly free from fluctuation. The blood, varying in quantity from a few ounces to half a gallon, is of a dark-brown color; or, if some time has elapsed, of the color of coffee grounds, partly fluid and partly coagulated. In old cases it is occasionally lamelliform and organized, as in an aneurismal sac. The vaginal tunic may be natural, opaque and wrinkled, thickened and indurated, or soft and pulpy. The testis is generally sound. The hemorrhage may be caused by the spontaneous rupture of a vessel; but usually it is referable to a wound, bruise, or blow. The disease may occur alone, or in union with hydrocele, when it is commonly produced by tapping. In a case of hematocele, described by Bochart, in a man, fifty-one years of age, the tumor extended into the abdomen, and was lost in the bottom of the left iliac fossa.

Hematocele is distinguished from other affections by its sudden development, its solid feel, the absence of translucency, its dark color, its obscure fluctuation, and the fact that it is almost always occasioned by external injury.

The indication is to prevent inflammation, and to encourage the removal of the effused blood by sorbefacients, of which a strong aqueous solution of hydrochlorate of ammonia, with the addition of a little vinegar, is generally the most powerful. Acetate of lead and Goulard's extract are also excellent applications. If these



Hematocele of the Vaginal tunic of the Testicle.

means fail, and the blood acts as a foreign substance, causing pain, swelling, and suppuration, a free incision is made along the centre of the tumor, and the wound healed by the granulating process. When there is much thickening of the vaginal tunic, it may be necessary to cut away a portion of the diseased membrane. If the extravasation coexists with hydrocele, the tumor is evacuated with a lancet, and immediately after traversed with a seton.

SECT. III.—AFFECTIONS OF THE SCROTUM.

The scrotum is liable to wounds, inflammation, different kinds of eruptions, hypertrophy, tumors, varix, and carcinoma.

1. *Wounds* of the scrotum, of whatever nature, are treated as similar lesions in other parts of the body. If the edges are properly approximated, they generally heal with astonishing rapidity, even when the integument is involved to a great extent, or when both testicles are completely denuded. Considerable hemorrhage often attends, demanding the free use of the ligature. The parts should be well supported during the cicatrization.

Gunshot wounds of the scrotum, of which I have seen numerous cases, generally readily heal under simple water-dressing. When complicated with injury of the urethra and an escape of urine, they are liable to be followed by extensive sloughing, necessitating free incision. Such an effect is best prevented by the timely use of the catheter.

2. *Hematocoele* of the scrotum is usually caused by a strain, blow, or kick, producing a rupture of some of the vessels of the part, the contents of which are extravasated into the areolar tissue below the skin. Blood is also, at the same time, frequently effused into the spermatic cord and the vaginal tunic of the testicle. The scrotum is of a dark, livid color, feels unusually heavy and doughy, and suddenly increases very greatly in bulk. The affection is similar to extravasations of blood in other regions, and requires similar treatment.

3. *Inflammation* of the scrotum may present itself in various forms, as the simple, traumatic, and erysipelatous, of which the latter is the only one requiring even a passing notice. It may exist by itself, or in union with similar disease in other parts of the body, and demands particular attention on account of its liability to terminate in sloughing. Elderly persons, of dilapidated constitution and intemperate habits, are its most frequent subjects. The disease is characterized by extensive swelling, from the infiltration of sero-plastic matter; the parts feel doughy and inelastic, readily pitting on pressure; the pain is of a smarting, burning nature; and the surface is of a pale-reddish, glossy appearance. More or less constitutional disturbance is present, the symptoms not unfrequently assuming a typhoid type. Extensive sloughing may occur, exposing the testes merely suspended by their cords.

There is a form of erysipelas of the scrotum which, from the peculiarity of its symptoms, is very liable to be mistaken for infiltration of urine. It was originally described by Robert Liston under the name of "inflammatory oedema," and often follows upon sores, abrasions, or eruptions upon the genitals and neighboring surfaces and fistules upon the perineum and anus. The case progresses rapidly; there is enormous swelling of the scrotum and penis, of a glossy-reddish aspect, very painful, and pitting deeply on pressure; the pulse is small, quick, and tremulous; the respiration is frequent and embarrassed; the countenance is pale and dejected; micturition is difficult, if not impracticable; the strength soon gives way; and, if relief is not speedily afforded, the parts are attacked with gangrene, followed by death. In the worst forms of the disease, the swelling extends to the groins, hypogastrium, perineum, and upper and inner regions of the thigh. In a case recently under my care, in a man of middle age and intemperate habits, the size of the scrotum fully equalled that of the head of a child one year old.

The diagnosis of this form of erysipelas rests mainly upon the history of the case, as the absence of previous urinary trouble, the rapidity and great extent of the swelling, and the facility with which the bladder may be reached by the catheter.

The treatment consists in attention to the general health by means of tonics, stimulants, and alterants, and in the application of tincture of iodine, with saturnine and anodyne fomentations, the parts being suspended in the usual manner. Tension is relieved, and matter evacuated, by suitable incisions.

4. A peculiar *sloughing* disease occasionally occurs in the scrotum of young chil-

dren. In a case which I saw many years ago in an infant two weeks old, an eschar, about an inch in diameter, suddenly formed over the right testicle, leaving the vaginal tunic perfectly denuded, and producing an angry-looking sore, with hard, glossy edges, reposing upon black-colored cellular tissue. The spermatic cord was indurated, tumid, and remarkably tender on pressure. The constitution did not seem to suffer much. In the course of twenty-four hours after these symptoms were discovered, the vaginal sac became distended; and, on puncturing it, a considerable quantity of sero-purulent fluid, of a yellowish color, followed the lancet. A small portion of the membrane now sloughed, leaving the gland quite bare. Under the use of nitrate of silver and a yeast poultice, granulations gradually sprouted up, and the infant got well without any constitutional treatment.

5. *Psoriasis* sometimes forms on the scrotum, the skin of which becomes cracked or fissured, red, inflamed, thickened, and affected with the most intolerable itching. The disease, which is often associated with psoriasis of the perineum, anus, groin, and inside of the thighs, is produced by various causes, both local and constitutional, and is mostly met with in middle-aged and elderly subjects, of a delicate skin, and light complexion. It is frequently very intractable, and then always constitutes a source of excessive suffering.

In the treatment of this affection, diligent search must be made for the exciting cause, the removal of which alone often promptly arrests the morbid action. In general, it will be found to be intimately connected with disorder of the constitution, or derangement of the digestive organs, thus pointing to the necessity of a properly regulated diet, the employment of purgatives, and the exhibition of alterants, as blue mass and ipecacuanha, along with antimonial and saline preparations. Iodide of potassium and sarsaparilla are of no use. The best local remedies are weak solutions of iodine, acetate of lead, and bichloride of mercury. In my own practice, however, I have found no application so soothing and effectual as the dilute ointment of nitrate of mercury, in the proportion of ten grains to the drachm of simple cerate. Zinc ointment is also a very excellent remedy.

6. *Hypertrophy* of the scrotum, sometimes existing as a congenital defect, is usually the result of long-continued distention and pressure consequent upon hernia, hydrocele, varicocele, and other tumors. It presents itself in varying degrees, from slight increase of the parts to the development of a tumor of large bulk and firm consistence. The treatment is palliative and radical; the former consisting in steady, systematic suspension, the latter, in careful retrenchment either with the knife, or, what is preferable, because less likely to be followed by troublesome hemorrhage, the *écraseur*.

7. The *sebaceous tumor* is occasionally met with in this situation immediately beneath the skin, which is generally so thin and transparent as to allow the contents of the growth to be distinctly visible. It sometimes occurs in considerable numbers. In one case, that of a young man, twenty-four years of age, recently under my care, upwards of one hundred existed, from the volume of a millet seed up to that of a pea. In another case, which I saw along with Professor Pancoast, the whole scrotum was literally covered with sebaceous tumors. They were very hard, rounded, ovoidal or angular in shape, closely grouped together, perfectly insensible, and speckled upon the surface as if they contained earthy matter. The largest were fully the size of an ordinary hickory nut. The patient was an elderly man, the subject of epithelioma of the anus. The sebaceous tumors had made their appearance at the age of twenty-three years. Interference is unnecessary, unless the tumors are so large as to incommode by their bulk and weight, which, however, is seldom the case.

8. The *cystic tumor* of the scrotum is very uncommon. It is composed, as the name implies, of cysts filled with serous fluid, and interspersed with fibroid substance, its original seat being apparently in the subcutaneous connective tissue. The number of cysts is variable, from twenty to thirty having been found in a single tumor, new ones being, doubtless, from time to time added to the old. Their volume ranges from that of a millet-seed to that of a pea; they are of a spherical or globular shape, and as they increase in size and number, as they always do very slowly, they encroach upon the scrotum, imparting to it a rough, nodulated appearance, which, with a faint sense of fluctuation, and a certain degree of elasticity, affords the only evidence of their existence. The proper remedy is excision. An excellent illustration of the character and structure of this variety of morbid growth is furnished in figs. 624 and 625, from Curling.

A cystic growth, the size of an apple, perfectly translucent, and filled with an actuous, yellowish fluid, has been described by Bauchet as having been situated in the cellular tissue of the scrotum. It was firmly connected with the integument, actuated distinctly under pressure, and was supposed to have had its origin in one of the sebaceous follicles of the skin.

Fig. 624.



Fig. 625.



Cystic Tumor of the Scrotum, Exhibiting its External and Internal Characters.

9. The *fatty tumor* of the scrotum, also extremely rare, generally presents itself as a small nodule in the connective tissue, imparting, while it is small, the idea of the existence of a third testicle. It is of a doughy, inelastic feel, and seldom attains much bulk, although in a case operated upon by Dr. Gilman Kimball, of Lowell, a growth of this kind, consisting of numerous hard masses of pure fat, weighed two pounds. The diagnosis is usually very obscure, but this is so much the less to be regretted as the only remedy is extirpation. In the case just referred to, the parts presented the characteristics of an old scrotal hernia.

10. The *fibrous tumor* of the scrotum is of uncommon occurrence. It is developed in the connective tissue, and is characterized here, as elsewhere, by its tardy growth, by its firm, dense consistence, by its sense of heavy weight, by the absence of pain, tenderness, and lymphatic involvement, and by the unimpaired state of the institution. It is most frequent after middle life, and is capable of acquiring enormous bulk. Some years ago, I operated upon a colored man, twenty-five years of age, removing a mass of this kind weighing nearly five pounds. It was of an ovoidal form, larger below than above, and was eight inches and a quarter in length by thirteen in circumference at its widest part. Its surface was perfectly smooth, and adherent, in the greater portion of its extent, to the vaginal tunic, by loose cellular substance. The testicle was situated at the lower extremity of the tumor, and, with the exception of being slightly flattened, had undergone no appreciable alteration. The deferent duct, also perfectly sound, ran along the posterior surface of the tumor.

A section of the mass exhibited a smooth, uniform surface, of a pale, grayish color. It was lightly elastic, almost incompressible, and remarkably solid, offering great resistance to the knife. A thin slice of it was opaque, and nearly as tough as sole leather. The tumor had been growing for upwards of five

Fig. 626.



Fibrous Tumor of the Scrotum.

years—during the last eighteen months very rapidly—but caused no other inconvenience than what resulted from its weight and bulk. The spermatic cord, the skin of the scrotum, and the glands of the groin were perfectly healthy. The patient recovered from the operation, but died some months afterwards of pulmonary phthisis. Fig. 626 exhibits the form and gross appearances of the tumor; the testicle is seen at the base, to the left of the middle line.

It is possible that many neoplasms described as fibrous tumors of the scrotum are in reality myomas, as in the case observed by Förster. Be this as it may, the fibrous growth, when very old, may be partially transformed into earthy matter, as in similar formations of the uterus, or be inlaid, as it were, with cartilage and even bone. A remarkable tumor of this kind has been reported by Dr. John G. Kerr, of Canton. The mass, which weighed five pounds after excision, was inlaid with large quantities of bony matter, exhibiting all the minute characteristics of osseous tissue. The patient, who made a good recovery, was only twenty-eight years old.

11. *Earthy concretions*, from the volume of a pea to that of an almond, now and then form in the scrotum, their number being sometimes quite considerable. Of a dull whitish, or grayish color, they are of a cretaceous consistence, and are composed mainly of phosphate and carbonate of lime, cemented together by a small quantity of animal matter. They are of tardy formation, and are found exclusively in middle-aged and elderly subjects, in connection with hypertrophy of the scrotum. The proper remedy is excision.

12. The scrotum sometimes contains cysts communicating with the urethra, or the urethra and bladder, and filled with *calculi*. The composition of the latter is variable, but, in general, they consist of uric acid; they are usually very smooth, ovoidal or spherical in their shape, and from the size of a millet-seed up to that of a Lima bean. Occasionally their bulk is enormous, as in a case mentioned by Graefe, the weight of which was twenty-six ounces. The patient, a shoemaker, had suffered for twenty years; he was in the habit of supporting the scrotum with a pad, and the concretion escaped one day during exertion in defecation. The number of calculi

Fig. 627.



Tittley's case of Elephantiasis of the Scrotum.

Fig. 628.



Bazeman's case of Elephantiasis of the Scrotum.

is sometimes remarkable, nearly as many as one hundred having been found in a single cyst. The cyst itself is commonly very thick, dense, and rough, especially in old cases. The only available treatment is excision.

13. The scrotum is liable to be transformed into a hard, fibrous mass, constituting what is termed *elephantiasis*. The enormous magnitude which this disease may attain is almost incredible. Titley removed from the scrotum of a negro a tumor of this kind, which weighed seventy pounds, and extended nearly down to the feet, as seen in fig. 627. Baron Larrey has detailed the particulars of one which was supposed to weigh one hundred and twenty pounds. In the medical museum at Montpellier is a diseased mass of this character, preserved by Delpech, the weight of which is one hundred and sixty pounds. In my private collection is a specimen of elephantiasis, presented to me by Dr. Bozeman, of New York, of forty pounds. The mass began to appear early in life, and grew until the patient, a colored man, was twenty years old, when it was excised by that distinguished surgeon. The adjoining cut, fig. 628, exhibits an excellent view of this tumor.

The disease, seldom observed in this country or in Europe, is sufficiently frequent in India, Asia, Africa, South America, and the West Indies. Externally, the morbid growth is rough and fissured, and its surface, particularly in old cases, is covered with yellowish, scaly crusts, the detachment of which leaves many small, herpetic sores, emitting a thin, ichorous discharge. The skin is very thick and indurated; the cellular tissue is firm and callous, its cavities being replaced by a dense, inelastic, fibroid substance; the bloodvessels are remarkably large, varicose, and ensheathed by lymphoid cells; and the swelling is indolent, incommoding rather by its weight and bulk than by its pain. In its shape it is mostly pyriform, but sometimes ovoidal, or globular. The testicle is not necessarily implicated in the disease, nor is the spermatic cord so much indurated and enlarged as in some of the other disorders of the genital apparatus. The morbid mass occasionally ulcerates; and a case has been related by Hendy in which it was invaded by mortification, causing the death of the patient. The disease is often complicated with hydrocele or scrotal hernia.

Dr. Fayrer, of Calcutta, has described a variety of this affection to which he has applied the term *nevroid*, as it is composed, in part, of erectile tissue, immediately underlying the surface of the morbid growth. Its occurrence is uncommon.

In the early stage of this disease relief may be attempted, although even then with hardly any prospect of success, by means of sorbefacients and systematic compression, steadily pursued for many months together. When the growth has acquired a large bulk the only remedy is excision, performed with special reference to the avoidance of hemorrhage and shock, which have nearly always proved fatal when the tumor has been of extraordinary size. If I had to deal with such a case, I should be tempted to cut away the mass piecemeal at several sittings, tying the vessels as they are divided, and using the actual cautery to sear, if necessary, the raw surface. Or, instead of this, removal might be effected partly with the knife, and partly with the *écraseur*. Or, perhaps, the best plan of all would be that suggested, and so happily practised, by Brett, Fayrer, O'Farrall, and others, of elevating the tumor and pressing out its venous blood immediately prior to the excision. In an operation performed by the latter in 1842, an enormous mass of this kind was successfully removed in eight minutes, with the loss only of five ounces of blood, and the preservation of the genital organs. Liston and Key, in a similar case, each lost his patient upon the table, while that of Dr. Bozeman died nearly a fortnight after the operation from peritonitis caused by extension of the inflammation along the spermatic cord. Both testes were included in the incisions, and the man lost twenty ounces of blood. One of the most successful operations of this kind upon record was performed in 1837, by Dr. Picton, of New Orleans. The tumor, which had existed for ten years, weighed fifty-three pounds. In the case of a negro, twenty-two years of age, in the hands of Dr. J. S. Thebaud, of New York, the result was equally gratifying, notwithstanding the large volume of the tumor, the weight of which was fifty-one pounds and a half, and the greatest circumference forty-eight inches. A full report of the case is contained in the New York Medical Journal for May, 1867.

Dr. Esdaile, of Calcutta, has performed this operation upwards of one hundred and sixty times, with a mortality of only five per cent., and in no instance, he adds, was death directly due to the operation. The testicles and penis may almost always be saved when the weight of the tumor does not exceed fifty pounds. In 113 cases operated on at the Medical College Hospital of Calcutta, from 1859 to 1867, 21 died, giving a percentage of 18.58. Pyæmia, diarrhœa, and exhaustion were the chief causes of death. Great size does not seem to compromise the result. In 4 success-

ful cases in the hands of Clot-Bey, of Egypt, the weight was, respectively, 65, 70, 80, and 110 pounds.

14. The scrotum has been known to contain *dermoid cysts* filled with various kinds of foetal remains, as pieces of bone, cartilage, teeth, hair, sebaceous matter, and even cerebral tissue. Remarkable cases of this description, all, as it seems to me, examples of monstrosity by inclusion, have been reported, among others, by Dietrich, Eke, André, Velpeau, Verneuil, and Van Buren.

The tumor, which is always congenital, and which ranges in size from an egg to that of the fist, is more or less irregular in shape, and varies very greatly in consistence, some parts being exceedingly hard and dense, while others are comparatively soft, or soft and even fluctuating, especially when, as occasionally happens, the affection is complicated with hydrocele.

The developmental force of the tumor is far from being uniform; in general, it keeps steady pace with that of the body, very much as in the natural state; in some cases, however, it is retarded, and in others it proceeds with unusual vigor, so that, ultimately, the mass attains a much larger bulk than common. Occasionally, in consequence, apparently, of the disintegration of some of the foetal structures, it takes on inflammation and suppuration, followed by the partial escape of its contents. No instance has yet been recorded where such a tumor became the subject of malignant disease. The foetal remains are generally described as being situated in the testicle, but this is by no means always the case, as this organ has sometimes been found to be perfectly sound.

The diagnosis is deduced chiefly from the history of the case, especially its congenital origin, and stationary character, and from the irregularity of the consistence of the tumor. Not unfrequently some of the foetal bones can be distinctly felt through the coverings of the scrotum, and sometimes they are distinguishable by the eye, finger, or probe, as they lie in the fistulous openings of the tumor. Velpeau, in an instance of this kind, based his diagnosis upon a tuft of hair protruding at an ulcer. In ten cases collected and analyzed by Verneuil, the discrimination was accurately determined prior to excision only in two. The affections with which it is most liable to be confounded are, encephaloid, tubercular disease, and syphilitic degeneration, all of which occasionally occur at a very early period of life. A careful observer would hardly mistake such tumor for a hydrocele or a scrotal hernia.

Excision constitutes the proper treatment. The testicle may sometimes be saved, but in most cases it is so intimately involved in the tumor as to require to be sacrificed. In the case of Velpeau, in which this organ was left behind, a long and tedious dissection was required, and the patient, a man, twenty-seven years of age, died of purulent infection soon after the operation.

15. *Varix* of the scrotum is uncommon, and is observed chiefly in old, bulky hydroceles and ruptures. In the case from which fig. 629 was taken, a man, nearly fifty years

Fig. 629.



Varix of the Scrotum and Penis.

of age, a patient at the College Clinic, the affection was conjoined with varix of the legs, abdomen, and penis. The enlargement, although enormous, created no particular inconvenience. The patient was a common laborer, fifty years old, otherwise in good health. Should the disease become a source of suffering, relief must be sought in suspension and astringent lotions; or, if need be, in subcutaneous ligation. Verneuil has described two cases of erectile venous tumors, evidently dependent upon varicosity of the subcutaneous scrotal veins, and marked by a tendency to spontaneous inflammation.

16. A peculiar varicose affection of the lymphatic vessels of the scrotum, constituting *lymphangiectasis*, occasionally occurs. Dr. Carter, of Bombay, who has called particular attention to the subject in connection with a case in an adult Hindoo, describes the disease as consisting in a singularly corrugated and thickened condition of the skin of the scrotum, accompanied with numerous tubercles from the size of a pin's head to that of a pea, soft to the touch, and, when punctured, giving vent to a copious flow of milky fluid. The inguinal glands on both sides were much enlarged, of a doughy consistence, and diminishable under the pressure of the finger. The discharge alternated with a chylous condition of the urine. I saw a similar case of

lymphangiectasis in the summer of 1868, at the clinic of Professor Vanzetti, of the University of Padua. The disease had existed for five years, large quantities of lymph being discharged every few days.

17. *Carcinoma* of the scrotum is generally of the epithelial kind, and seldom occurs before puberty, its favorite period of attack being from the thirtieth to the fortieth year. It is most common in chimney-sweeps; hence it has by some been named the chimney-sweeper's cancer, seen in fig. 630. The affection ordinarily begins at the base of the scrotum, in the form of a small, wart-like excrescence, covered by a thin, scaly crust. After this has continued for a time, the hardened cuticle sloughs, leaving a superficial, painful, ill-looking ulcer, with indurated and everted edges. The surface of the sore has a red, excoriated aspect, and discharges a thin, sanguinolent fluid, often highly irritating and offensive. In this way the morbid process gradually extends, until at length a large surface of the scrotum, together with the vaginal tunic, and the exterior of the testicle, is involved in the disease. In this advanced stage, the cellular tissue around the sore is generally white and scirrhus; and the inguinal glands on one or both sides are enlarged, injected, and, in some instances, filled with carcinomatous matter.

The progress of carcinoma of the scrotum is generally comparatively slow; there is less local and constitutional suffering than in carcinoma of other parts of the body, and death seldom occurs under four or five years. A case has been reported of a chimney-sweep who lived upwards of forty years with a disease of this kind. The diagnosis of carcinoma of the scrotum is sufficiently easy, the peculiar appearance, situation, and feel of the tumor, and the history of the case, always serving to distinguish it from other affections. The only remedy is early and free excision, before there is any lymphatic involvement.

18. *Encephaloid* and *melanosis* of the scrotum are very uncommon, especially as primary diseases. They may begin either in the skin, or, as is more commonly the case, in the subcutaneous areolar substance, from which, as they increase, they gradually extend to the other structures. I have seen a number of examples of melanosis, but in none did the malady involve the scrotum. Curling mentions a case in which he removed a tumor of this kind, evidently of primary formation, from the scrotum of a man, thirty-two years of age. It was of a dark color, and about the size of a small walnut, with a narrow pedicle. The disease returned soon after the operation, in the vicinity of the cicatrice, and, gradually invading the inguinal and lumbar lymphatic glands, carried off the patient, but not until after the lapse of six years.

19. *Amputation* of the scrotum may be required on account of simple hypertrophy, elephantiasis, or malignant disease. The operation, in the more ordinary forms of these affections, is readily performed with the knife, with the precaution of avoiding the testicle, and tying up the bleeding vessels immediately after the completion of

Fig. 630.



An aggravated Example of Chimney-Sweeper's Cancer, with much Destruction of the Superficial Textures.

Fig. 631.



the incisions. Secondary hemorrhage is what is principally to be dreaded after such an operation, and should, therefore, be specially guarded against. The edges of the wound should be approximated with the interrupted and twisted sutures, retained for an unusual period, otherwise extensive separation will almost be certain

to occur, the wound having a great tendency to gap. E the cure of elephantiasis, has already been described. trophy, attended with excessive elongation, the redun be advantageously removed without any risk of hemor seur or the instrument of Dr. M. H. Henry, of New Yor

SECT. IV.—AFFECTIONS OF THE SPERMAT

The spermatic cord is liable to injury, inflammation, s lations of blood, and various kinds of tumors. In absen is generally very small, and the deferent tube terminates the groin.

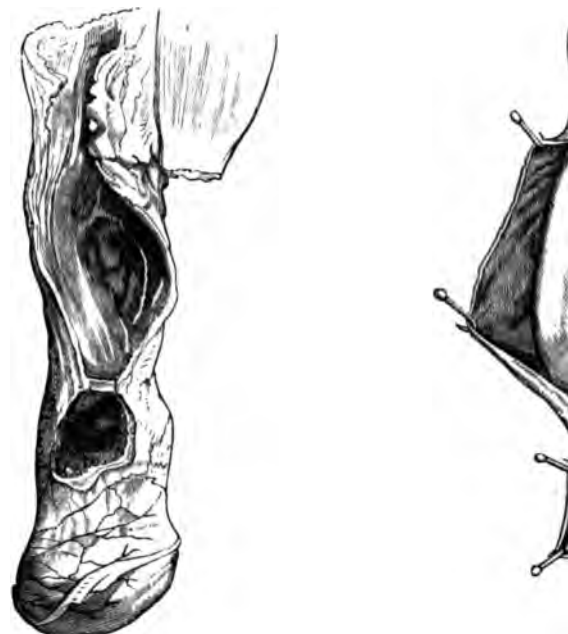
1. *Wounds and Contusions*.—Wounds and contusions rally coexist with similar lesions in the neighboring part be followed by wasting of the testicle, especially when tube. Copious hemorrhage may attend the division of t be promptly checked with the ligature, the opening b enlarged to afford the required access.

2. *Inflammation and Abscess*.—Inflammation of these an independent affection; in general, it is caused by an the testicle, as in gonorrhœa or syphilitic orchitis. It hardness, pain, and tenderness of the cord, accompanied more or less constitutional disturbance, and is to be treu gistic principles, with the addition of mercury and the ic specific nature. The disease occasionally passes into al rence is very uncommon, and requires no particular notic

3. *Hydrocele*.—Hydrocele of the spermatic cord o of form, the encysted and the diffused, the first being of the two.

In the *encysted hydrocele*, fig. 632, the tumor is disti

Fig. 632.



Encysted Hydrocele of the Cord.

Diffused

oval figure, from the size of a small marble to that of a b limpid or pale straw-colored fluid. Fluctuation and marked, may be entirely absent. The swelling, which is

and distinct from the testicle, receives no impulse in coughing, and cannot be emptied by pressure; circumstances which clearly distinguish it from hernia and hydrocele of the vaginal tunic. It may be situated at the upper part of the scrotum, just below the external ring, or even in the inguinal canal. The cyst of which it is composed, and which is, sometimes, very dense, thick, opaque, or even of a fibrous, cartilaginous, or calcified texture, is generally single, and originates, either adventitiously, or, as is more probable, in an imperfect obliteration of the tubular prolongation of the peritoneum, lying under cover of the common integument, superficial fascia, and fibres of the cremaster muscle. The affection, although it occurs at all periods of life, is most common in infants. It may vanish spontaneously, and should never be interfered with so long as it does not cause any serious inconvenience. In all cases demanding treatment, fair trial should be given to mild means; if these fail, as they generally do in adults, the best remedy is a slender seton, introduced with a small, curved needle, and retained until the part is slightly inflamed. The operation, however, is not devoid of risk, and should, therefore, be performed with great care. In a case mentioned by Curling, severe inflammation extended along the cord into the pelvis, causing suppuration in the iliac fossa, and, for a time, seriously endangering the patient's life. Pott relates a case treated by incision that proved fatal on the seventh day from inflammation. In the child a simple puncture is often sufficient to effect a cure. When this fails, the retention of a single thread in the sac for twelve to twenty-four hours will be sure to provoke obliterative action.

A very rare form of *congenital hydrocele* of the cord is sometimes observed, the sac communicating directly with the peritoneal cavity, but not extending far, if at all, beyond the external inguinal ring. The affection is liable to be confounded with inguinal hernia, with which, in fact, it occasionally coexists. Nannoni relates the particulars of a case, in which, supposing the disease to be of the latter character, he tied the sac, causing the death of the patient, a child six years of age.

In *diffused hydrocele*, fig. 633, the fluid accumulates in the connective tissue of the cord, the meshes of which, scarcely perceptible in the natural state, are converted into cells, from the size of a pea to that of a hazelnut. Gradually some of these cells give way, from the pressure of their contents, and thus one or more large cavities are formed, which are always most distinct at the base of the swelling. The hydrocele, at its commencement, is of a cylindrical shape; but, at a later period, it becomes pyramidal when the patient stands, and oblong, or nearly of equal dimensions throughout, when he is recumbent. It is inclosed in a membranous sheath, which is covered by the cremaster muscle, and extends from the testicle, which is below, to the external ring, into the inguinal canal, and occasionally even into the abdominal cavity. A tumor of this description has a uniform surface and definite shape, is slow in its formation, is not attended with any considerable pain, and is separated from the vaginal tunic by a distinct septum. It is liable to be confounded with omental hernia, but is distinguished from it by not receiving an impulse in coughing, by its imperfect removal under pressure, by the fluctuation at its lower part, and by the change of figure which it undergoes in the recumbent position. Acupuncture will sometimes effect a cure, especially if aided by pressure with a compress and roller; but a small seton is a safer and surer remedy. Free incision, as practised by Pott, is not to be thought of. As long as the tumor is small, and produces no pain or inconvenience, interference is unnecessary.

4. *Hematocoele*.—Hematocoele of the spermatic cord, fig. 634, is uncommon, and is nearly always associated with, or consequent upon, encysted hydrocele. It occurs in two varieties of form, the traumatic and spontaneous. The symptoms are similar to those of ordinary hematocoele. The tumor is hard, small, semifluctuating and filled with grumous blood, or bloody serum, which imparts to it a dark color. The only disease with which it might be confounded, especially in its earlier

Fig. 634.



Encysted Hematocoele of the Cord.

stages, is inguinal hernia; but from this it may generally be easily distinguished by the history of the case, the irreducibility of the swelling, and, if need be, by the introduction of the exploring needle. The tumor sometimes acquires an enormous bulk and weight. Thus, in a case reported by Mr. Bowman, of London, it reached down to the knee, and was so heavy as to require both hands to raise it. The treatment is the same as for hematocele of the vaginal tunic of the testicle. Care is taken not to make too early an incision, lest difficulty should arise in securing the vessels, the rupture of which has caused the disease.

5. *Varicocele*.—By varicocele is understood a dilated and tortuous state of the veins of the spermatic cord. It generally arises soon after puberty, but occasionally it occurs later, and now and then I have met with it as early as the eleventh year. It is almost exclusively confined to the left side, for the reason, as Dr. John Brinton, of this city, has shown, that the left spermatic vein, at its entrance into the emulgent, is unprovided with a valve, whereas such an arrangement exists distinctly on the right side, where the vein embogues into the vena cava. Besides, the left vein is naturally considerably longer than the right, and its direction, also, is more at a right angle with the current of the blood.

The affection may be induced by whatever has a tendency to facilitate an afflux of blood to the genital organs, or to serve as a habitual barrier to its return to the heart. Hence, the most common causes are, venereal excesses, masturbation, chronic disease of the scrotum and testicle, riding on horseback, bodily fatigue, and pressure on the spermatic vessels from distention of the iliac portion of the colon, the presence of tumors in the groin or pelvis, and the wearing of ill-constructed trusses. Constant relaxation of the scrotum, however induced, powerfully predisposes to the formation of the disease. It is very probable that there exists in many cases, if not in most, a natural tendency to this enlargement. What corroborates this idea is that it often begins very early in life, before the causes here referred to can exert any injurious influence, and the fact that it occasionally occurs in several members of the same family.

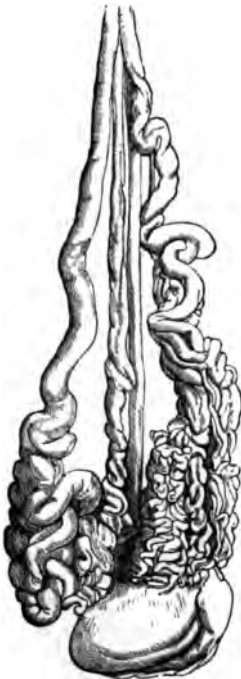
Varicocele is usually slow in its progress, and is attended with a dull, heavy, aching pain, which often extends up the cord to the groin and even to the back. In some cases the pain is of a neuralgic nature. A sense of weight is commonly experienced in the testicle, which is liable, eventually, to become

soft and shrunken, from the pressure of the enlarged and distended veins. The scrotum of the affected side is very subject to perspiration, and is often remarkably flabby, elongated, and pendulous, especially after exercise. The general health rarely suffers; but in many cases there is a gloomy and melancholy state of the mind, almost bordering upon alienation, and unfitting the patient for active exertion.

When the disease is fully developed, the veins are convoluted, knotty, elongated, harder in some places than in others, and irregularly dilated, some of them being more than six times the ordinary volume, as seen in fig. 635. Their parietes are very thick, dense, and rigid at some points, and very brittle and attenuated at others. In cases of long standing, some of the vessels are completely obliterated by adhesive inflammation, or by the formation of fibrinous concretions. Phlebolites are also occasionally found in them. The connecting cellular tissue does not experience any particular alteration, but the veins of the testicle itself are often considerably enlarged, as are also those which ramify between the vaginal and albugineous coats.

The tumor resulting from the enlarged and dilated veins is of an elongated, conical shape, irregular and compressible, feeling very much like a bundle of cords, a cluster of earth-worms, or a mass of the intestines of a rat. It has neither the regular outline and elastic feel of hydrocele, the firmness and globular character of sarcocele, nor the doughy consistence of scrotal hernia. The distended vessels are frequently distinctly visible through the skin. When the tumor is very voluminous, it may extend from the lower

Fig. 635.



Varicocele.

margin of the testis to the external ring; and in this case there is always considerable enlargement of the subcutaneous veins of the scrotum.

Although the symptoms of varicocele are usually well marked, the diagnosis is not always readily determined. The affection for which it is most liable to be mistaken is scrotal hernia, especially that variety in which the omentum is concerned. In order to distinguish between the two diseases, the patient is placed on his back, and the scrotum held up until it is entirely empty; the finger is then applied to the external ring, and the patient requested to rise, when, if the tumor be a varicocele, it will immediately reappear, whereas, if it be a hernia, the bowel will be unable to descend. A more certain mode of determining the diagnosis is to compress the neck of the swelling, in the erect posture, when, if composed of intestine, it will remain stationary, but become more tense if it consist of dilated veins.

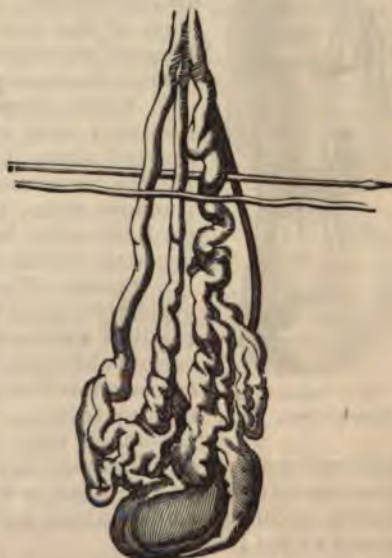
Treatment.—The treatment of varicocele is palliative and radical. The former, which, in ordinary cases, is alone resorted to, consists in wearing a gum-elastic bag, in washing the parts frequently with cold water, or some astringent lotion, and in carefully avoiding everything tending to favor a determination of blood to the spermatic vessels. To obtain full advantage from these measures, the patient must pay strict attention to his bowels, and refrain from horseback exercise, fatiguing walks, protracted standing, dancing, warm bathing, and venereal excesses.

The radical cure is required when there is a great deal of local suffering, with danger of atrophy of the testicle; or, when the patient's mind is so much affected as to render him not only wretched but utterly unfit for business. The disease, as is well known, is a cause of disqualification for admission into the army and navy, and I have in several instances considered myself justified in performing the operation solely on this account. When there is much mental distress, I should not hesitate to interfere, although the enlargement should be comparatively insignificant, in order to restore the patient to comfort and usefulness.

Almost innumerable operations have been proposed and performed for the radical cure of this complaint. With some of the ancients the actual cautery was a favorite remedy. Gooch and other surgeons have reported cases cured by castration; some prefer ligation, others excision, of the affected veins; occasionally the spermatic artery has been tied; in the hands of Breschet, compression with a pair of flattened screw-forceps is said to have frequently succeeded; Sir Astley Cooper has recommended excision of a portion of the scrotum; and Velpeau, Davat, Frické, Grossheim, Reynaud, and Vidal have each devised and practised ingenious subcutaneous operations for its relief. The method which I formerly employed consisted in exposing the enlarged veins, and strangulating them with the twisted suture. The scrotum having been rendered tense by grasping it behind with the left hand, a vertical incision, about an inch in length, was made over the anterior part of the swelling, down to the vessels, which were then carefully isolated from the accompanying duct, artery, and nerves, by a few touches of the point of the scalpel. A slender darning needle was next passed underneath the enlarged trunks, and secured by passing around it a stout thread, in the form of the figure 8. The operation was finished by closing the wound with the twisted suture. In twenty-four hours the large needle was removed, and the strangulated mass divided with a narrow bistoury.

I had performed this operation with the most gratifying results in fifteen cases, when one of my patient's unexpectedly perished from phlebitis and pyemia; a circumstance which led me to abandon it. For many years past, I have limited myself altogether to subcutaneous ligation, which I believe to be perfectly safe under all circumstances, as well as permanently successful. The operation consists in tying

Fig. 636.



Operation for Varicocele.

the enlarged veins, previously isolated, as in fig. 636, from the deferent tube, with a stout cord, well waxed, or, what is less likely to cause trouble, a silver wire, passed with a long spear-shaped needle, from before backwards, in such a manner as to leave two apertures, one in front and the other behind, as is easily done, simply by compelling the instrument to retrace its steps. Or, instead of this, the operation may be performed, as I have in a number of instances, by making only one puncture, by carrying the extremity of the needle around the enlarged veins, beneath the scrotum, and then pushing it out at the opening of entrance. Whichever method be adopted, the proper plan is to tie the ligature firmly over a broad perforated button, as suggested by Dr. William H. Pancoast, care being taken to tighten it occasionally in order to render the pressure more effective. If wire be used, the ends are twisted instead of being tied. I seldom withdraw the cord before the end of the twelfth day, when the veins are generally sufficiently divided and occluded to prevent a return of the circulation. The patient is kept in bed upon light diet, with the scrotum well suspended, and constantly wet with lead water, half a grain of morphia being administered immediately after the operation, which is always performed with the aid of chloroform. The hardness and swelling, consequent upon the ligation of the veins, gradually disappear spontaneously, or under the influence of sorbefacient applications.

When the scrotum is very flabby and pendulous, the superfluous portion should be retrenched with the knife; care being taken to tie up every bleeding vessel, and to approximate the edges of the wound with the continued suture, which answers much better here than the interrupted. I have performed this operation repeatedly with very excellent results.

Fig. 637.



Fatty Tumor of the Spermatic Cord.

6. *Fatty Tumors*.—The spermatic cord is liable to accumulations of adipose matter, constituting what is called a fatty tumor. The deposit begins in the connective tissue, and occurs either as a distinct, circumscribed tumor, as in fig. 637, composed of numerous lobes, held together by cellulo-fibrous substance, or as an elongated, undefined mass, extending for many inches along the cord. The morbid growth is sometimes associated with hernia of the groin, and, from its doughy, inelastic feel, indolent character, and fixed position, is liable to be mistaken for an irreducible omentum. From hydrocele of the cord it is distinguished by the tardiness of its development, by the absence of fluctuation, and by the variable form of the tumor. So long as it causes no inconvenience, no surgical interference is required, but extirpation will be necessary when it becomes painful or oppressive from its weight and bulk.

7. *Cystic Tumors*.—An encysted tumor, consisting either of a solitary, oval, or globular cell, or a group of cysts, of variable size and shape, has occasionally been seen in the spermatic cord, but the occurrence is too infrequent to be of any practical interest. Nannoni states that he had met with hydatids in the spermatic cord, but as he has not given a detailed account of the case, it is uncertain whether the disease was really of this character.

8. *Spasm*.—The spermatic cord is occasionally the seat of spasm, evidently caused by irritation of the cremaster muscle, either as a result of external injury, disease of the kidney, the passage of a calculus along the ureter, or stricture of the urethra. The spasm comes on suddenly, and is characterized by the forcible retraction of the testicle, which is firmly pressed against the external abdominal ring. The patient usually experiences more or less pain and tenderness in the part during the continuance of the attack, as well as for some time after. The affection is to be treated with anodyne fomentations, the cold douche, soothing embrocations, and the belladonna plaster, with attention to the source of the irritation.

9. *Specific Diseases*.—Finally, the spermatic cord is liable to syphilitic and carcinomatous disease. In syphilitic sarcocele, the cord, especially in the lower portion of its extent, is generally very much thickened and indurated, feeling like a piece of sole-leather, painful and tender on pressure. Great enlargement of the cord also frequently exists in encephaloid and other forms of carcinoma of the testicle and scrotum, but it is questionable whether it suffers primarily from these affections.

SECT. V.—AFFECTIONS OF THE PENIS.

This organ is liable to inflammation, gangrene, wounds, morbid erections, ulcers, degeneration of its sheath and septum, carcinoma, and a peculiar incurvation usually associated with abnormal shortening.

1. *Inflammation* of the penis may either begin in this organ, or be propagated to it from the neighboring parts, as the scrotum, groin, or pubes. Generally caused by external injury, or specific disease, as chancre or gonorrhœa, it occasionally assumes an erysipelatous character, and produces great pain and swelling of the entire organ, accompanied with a constant tendency to erections. The affection, however induced, is easily recognized, and usually promptly yields to the ordinary antiphlogistic measures.

The more severe forms of inflammation of the penis are occasionally followed by gangrene, especially when the disease has been induced by chancre in a person of an anæmic, broken-down constitution. The destruction may involve the entire organ, or it may be limited to certain portions, as the glans or prepuce. A case of mortification of the penis, strangulated by a key-ring, causing the death of the patient, may be found in Ranking's Abstract for 1845. The treatment must be conducted upon general principles.

The penis occasionally suffers from gangrene in paraplegia; and a case in which the disease arose spontaneously has been recorded by Mr. Partridge, of London. The man, who was forty years old, on being admitted into the hospital, was in a low typhoid condition, and the organ was black and cold nearly down to the scrotum, where it ultimately dropped off.

2. *Wounds* of the penis may be accidental or self-inflicted, and may present themselves in various forms and degrees. Whatever their character may be, they are apt to be followed by copious hemorrhage, and by troublesome erections. The bleeding thus produced may generally be temporarily controlled by compression of the dorsal artery of the penis, made by grasping the organ firmly at its root with the thumb and index finger.

Gunshot wounds of the penis are uncommon, perforation of the organ being rendered difficult by the toughness of the envelops of the erectile tissues. After the battle of Bull Run, I saw a case in which the ball passed completely through the head of the penis, leaving two openings, which, however, soon healed. When the missile carries away a portion of the urethra, infiltration of urine may occur, especially if the use of the catheter is neglected; in any event, a fistule will be likely to be left. A gunshot wound of the root of the cavernous bodies is liable to be followed by impotence, from the inability of the patient to command erections. Dr. S. W. Gross has recorded a case in which a conical ball lay encysted in one of these structures, its point presenting towards the pubes, from which it was separated about one inch. The man experienced so little inconvenience that he refused to have it extracted.

The treatment must be regulated by the same precepts as in similar injuries in other parts of the body. When the organ is partially separated by a clean cut, stitches should be freely used, along with strips of collodion and splints, care being taken afterwards to prevent displacement by guarding against the occurrence of erections. In the event of complete severance, reunion may reasonably be expected to ensue, provided the parts are promptly and securely restored to their natural position over a catheter. Cold water-dressing ordinarily constitutes the best application.

3. *Laceration* of the fibrous sheath of the cavernous body of the penis is occasionally met with; generally as a consequence of a blow while the organ is in a state of inordinate erection, during sexual intercourse, or in the act of onanism. The occurrence of the accident, of which interesting cases have been reported by Mott, Ruschenberger, Rathburn, Huguier, Bins, and other observers, is generally denoted by a feeling as if something had suddenly given way, instantly followed by collapse, and a copious extravasation of blood, distending the organ in every direction, and rapidly diffusing itself over the neighboring parts, as the scrotum, perineum, and even the pubes. Sometimes a distinct noise is heard at the moment of the rupture, not unlike the crack of a whip. The penis is commonly inclined a little towards the sound side, and the seat of the injury is readily distinguished by the finger. When the urethra is torn, extensive infiltration of urine will be likely to occur, and

may be followed by mortification and death, as in the interesting cases reported by Huguier, Demarquay, and Bins. If the patient recovers, the organ sometimes remains permanently unfit for sexual intercourse.

The treatment of this affection is by rest of the penis in an elevated position, with discutient applications, as saturnine and spirituous lotions, followed by dilute tincture of iodine, soap liniment, and tincture of arnica and camphor. If blood is extensively effused into the cavernous structure of the penis, a free incision should be made, to squeeze out the clots, otherwise they may become intermixed with lymph, and thus undergo partial disorganization, much to the detriment of the functions of the organ. When the urethra is ruptured, the catheter must be promptly inserted to prevent urinary infiltration.

An interesting case of laceration of the urethra in the act of coition in a man, thirty years of age, has been recorded by Dr. Louis Bauer. The accident was succeeded by copious hemorrhage, and extensive infiltration of blood into the penis, scrotum, perineum, and groins. The catheter was inserted with difficulty, and, although it was permanently retained, an abscess formed, followed by troublesome fistule.

Rupture of the superficial veins of the penis generally occurs from blows or falls; and may be attended with copious extravasation of blood, necessitating the employment of refrigerant and sorbefacient lotions for its removal.

4. A singular case of *luxation* of the cavernous bodies of the penis, in a child six years of age, has been recorded by Nélaton. In taking hold of the organ, a few days after the accident, to pass a catheter, it was found to be destitute of substance, as if, in fact, it were a mere cutaneous tube, similar to the empty cocoon of a silk worm. The missing bodies were lodged in the scrotum, from which they were drawn by a to and fro movement into their natural position by means of an instrument used for tying deep seated arteries. The final result of the case is not stated.

5. The penis is liable to *strangulation*, the accident being generally caused by the application of a ligature, fillet, or metallic ring, designed either as a means of relieving incontinence of urine, or as a self-inflicted punishment for morbid erections. When the constriction is unusually tight, or long continued, mortification may ensue, as in the celebrated case of J. L. Petit; or mortification and death, as in a case communicated to me by Dr. Kelly, of Manayunk, the patient being a man fifty-seven years of age, who had slipped a "bridal ring" over the root of the penis, where it soon excited violent inflammation. The treatment, in such an occurrence, obviously consists in dividing the foreign substance, whatever it may be, with the scissors, file, or pliers, and then scarifying, if need be, the infiltrated and distended parts. Sometimes the object may be effected by winding a stout and well-waxed silk thread around the penis, so as to constrict the organ as firmly as possible as far as the ring, beneath which the cord is then passed with a curved needle, when it is easily untwisted, thus carrying the ring with it.

Mr. Liston met with a very curious case of disease of the penis in a man upwards of fifty years of age, who, early in life, had slipped a brass curtain ring over the organ to prevent incontinence of urine. Inflammation and ulceration soon followed, and by degrees the ring became concealed below the skin, where, after many years of comparative harmlessness, it was finally incrustated with calculous matter, seriously interfering with micturition, and ultimately necessitating an operation for its removal.

6. *Phlebitis* of the penis is uncommon. I have, however, observed several well-marked cases of it in the dorsal veins, as an effect, apparently, of irritation produced by sexual intercourse. Sometimes it is a consequence of gonorrhœa. The disease, which is occasionally associated with angioloecitis, is characterized by a phlogosed, turgescient appearance of the organ, and by a tender, corded, and enlarged state of the dorsal veins, extending as far back as the root of the penis. Rest and elevation of the organ, the application of saturnine and anodyne lotions, light diet, and a brisk purgative, constitute the proper treatment.

7. *Morbid erections* of the penis may be produced by inflammation, followed by an effusion of lymph into the cells of the cavernous bodies. I have never inspected a case of this kind after death, but observed one several years ago in a young mechanic, which lasted for nearly four weeks, in spite of the most rigid antiphlogistic measures. It came on soon after intercourse, and was attended with excessive pain, together with much constitutional disturbance. For several months after the violence

of the disease had abated, the organ remained small, flaccid, and incapable of complete erection. Sometimes the priapism is occasioned by an effusion of pure blood, in which case, if the fluid be not removed, the individual may become permanently impotent. Priapism of a severe character sometimes supervenes upon injury of the spine and cerebellum. It may also be caused by the inordinate use of cantharides, by irritation of the prostate gland, urethra, anus, or rectum, and by congestion and various organic affections of the lesser brain. In children, troublesome priapism may be occasioned by an adherent prepuce.

Ordinary cases of priapism are treated with cold applications, and the liberal use of anodynes and of bromide of potassium. In the more severe forms, bleeding at the arm and by leeches, active purgatives, antimonials, and even slight ptyalism may be necessary. If retention of urine takes place, relief must be afforded with the catheter. When the morbid erections depend upon an effusion of blood, free incisions should be made to turn out the clots; if not all, as many as possible. Priapism, dependent upon irritation of the cerebellum, may require the application of leeches to the occipital region, and the establishment, in obstinate cases, of an issue in the nape of the neck. When it arises from irritation of the bladder, urethra, or prostate gland, one of the most valuable remedies, after the removal of the irritating cause, is bromide of potassium, in large doses, thrice a day, with an anodyne enema at bedtime.

8. *Ulcers* of the penis, specific and non-specific, are described in the chapter on syphilis, and need not, therefore, detain us here, beyond the statement that the subject is one of great practical importance, both as it respects the peace of mind and the physical welfare of the patient. I am satisfied, from much observation, that the most simple ulcers of the penis are frequently mistaken for syphilitic, and that, in consequence of these errors of diagnosis, persons are constantly subjected to severe courses of mercury that would get well in a very few days under the most simple treatment. I have seen many a constitution permanently ruined in this way.

9. The pectiniform septum of the penis is subject to the *fibrous and osseous transformations*. I recollect a singular instance of this kind in a patient of Dr. George McClellan, for whose relief he was obliged to perform an operation. The man was between fifty and sixty years of age; the disease had been coming on gradually; and the organ was curved towards the perineum to such a degree as to interfere materially with copulation. The operation, which consisted in the excision of the offending substance, was entirely successful. Such a lesion, as may readily be conceived, might become a cause of impotence.

The fibrous sheath of the cavernous body is sometimes affected in a similar manner as the pectiniform septum. The transformation, according to my observation, is most common in subjects from thirty to forty years of age, and usually occurs in small patches, from the size of a three-cent piece to that of a dime. Persons much addicted to sexual intercourse are, I believe, most liable to it. When several such spots exist, they may materially interfere with the erection of the penis, and thus become a source of great mental annoyance to the individual, seriously compromising his happiness.

The treatment of these affections is not very satisfactory. In their earlier stages, benefit may accrue from the application of sorbefacients, and subcutaneous scarification; but when the deposit is old, firm, and thoroughly organized, nothing short of excision will answer. The operation is sufficiently easy, and is not attended with any serious hemorrhage.

10. *Carcinoma* of the penis occurs chiefly in the epithelial form. It usually begins as a little wart, tubercle, or fissure, on the head of the organ or the foreskin, from which it gradually spreads to the other structures, until the greater portion is destroyed. The resulting ulcer is at first quite small and superficial; by and by, however, it becomes broader and broader, and, at last, throws out a cauliflower-like fungus. There is now a profuse discharge of thin, sanious, and offensive matter, the inguinal glands rapidly enlarge, and the patient is harassed with severe, lancinating pains, darting up towards the abdomen, his constitution being at the same time completely undermined by the local disease. Carcinoma of the penis is most common in old men, and its occurrence is generally supposed to be favored by the existence of a long and tight prepuce. Of the truth of this opinion, however, my own experience has not furnished me with any examples.

Epithelioma of this organ pursues a comparatively tardy course, and does not

relapse so soon after removal as carcinoma in other parts of the body. In one of my cases, that of a medical gentleman, upwards of fifty years of age, twelve years have elapsed since the operation, and still there is no sign of a return of the malady. Sooner or later, however, the disease breaks out again, despite all that can be done to prevent it. When amputation is performed, the knife must always be carried freely through the sound tissues. No operation is, of course, proper when there is serious lymphatic involvement.

11. *Melanosis* of this organ is very uncommon. The only case, in fact, of which I have seen any account is one recorded by Dr. Charles Murchison, of London. It occurred in a man, fifty-four years of age, beginning as a small excrescence on the prepuce, from which it gradually extended to the head of the organ, was of a dark brownish, almost black color, bled when rudely touched, and was the seat of acute pain. It had been progressing for two years when the man died, and coexisted with melanosis of the liver, pleura, lymphatic glands and other structures.

12. *Incurvation* of the penis is a congenital affection, complicated with abnormal brevity and hypospadias or malformation of the urethra, which is either deficient, or opens some distance behind its usual situation. The consequence is that the organ is bent very considerably backwards towards the scrotum, exhibiting thus not only an unseemly appearance, but interfering materially with copulation.

For the relief of this defect, an ingenious operation, originated by Dr. Physick, and since practised by Professor Pancoast, myself, and others, may be performed. The procedure, which, in principle, is essentially similar to that of Barton for the relief of ankylosis, simply consists in the excision of a V-shaped portion of the cavernous bodies, the first incision being made a few lines behind the head of the penis. The portion excised should be just large enough to remedy the deformity, and no more. No skin is removed, and care is taken not to interfere with the urethra. The arteries, generally three or four in number, being secured, the edges of the wound are carefully approximated by the interrupted suture, carried through the fibrous sheath of the cavernous bodies, the edges of the integument being tacked together separately. The organ is then placed in an elevated position upon a gutta-percha or leather splint, and kept constantly wet with cold water. Erections are controlled by the usual means. The stitches are removed in from eight to ten days. No untoward symptoms follow the operation, and the result is most gratifying.

13. The cavernous bodies of the penis are liable to *aneurism*, consisting in an abnormal dilatation of their cells. The affection, which is exceedingly uncommon, may be either congenital or acquired, and is characterized by the existence of a soft, spongy mass, susceptible of temporary expansion, and the seat of faint pulsation. It rarely involves the entire circumference of the cavernous bodies, much less their entire length. The diagnosis may usually be readily determined by the history of the case, and the peculiar nature of the enlargement. The skin generally remains sound. Albinus has recorded the particulars of such a growth which was punctured under the supposition of its being an abscess. The consequence was a copious hemorrhage, of which the patient died in a few days. The most reliable remedies are injections of subsulphate of iron, and subcutaneous ligation. When the case has been neglected, or the organ has become enormously enlarged, amputation may be required.

Malgaigne has recorded a unique case of traumatic aneurism of the dorsal artery of the penis in a young man who injured himself with his pocket-knife. After the wound was healed, a tumor formed near the root of the organ, progressively increased in size, fluctuated distinctly under pressure, and, on being laid open, and the clots turned out, it was found to have been fed by the vessel in question.

14. A case in which a *horn* grew upon the head of the penis, in a man, twenty-two years of age, has been recorded by Dr. P. A. Jewett, of New Haven. It was of a brownish color, lamellated, insensible, and three inches and a quarter in length by three-quarters of an inch in diameter at the base, gradually tapering to a point. Other benign tumors have been observed, either in connection with the glans or the cavernous bodies, but their occurrence is so rare that they do not demand special consideration.

15. *Amputation* of the penis, rendered necessary on account of carcinomatous disease, is one of the easiest procedures in surgery. The integument being slightly retracted by an assistant, the surgeon embraces the penis, behind the seat of the disease,

with a pair of slender polyp-forceps, inclining a little obliquely from behind forwards, and then, with one sweep of a small catlin, or large bistoury, severs it from above downwards. The arteries being drawn out and tied, the mucous membrane of the urethra is tacked at four different points to the edges of the cutaneous portion of the wound, to prevent contraction of the canal, so liable to follow the ordinary operation. No catheter need be inserted during the cure.

When the bleeding from the cavernous bodies is, as sometimes happens, unusually troublesome, the best way to arrest it is to transfix them with an acupressure needle, tightened by a ligature passed around it elliptically, as in the common harelip pin. The instrument is removed at the end of twelve to twenty-four hours.

Mr. Hilton has suggested what may be regarded as an improvement on the old plan of amputation of this organ. It consists in dividing the spongy structure of the urethra about a quarter of an inch in front of the cavernous bodies, in splitting the urethra longitudinally, and in tacking the lateral flaps thus made by suture to the margin of the integument. By this procedure retraction of the urethra is prevented, and cicatrization promoted.

Removal of the penis may also be effected with the *écraseur*. The integument should be drawn well forward, and the instrument worked very slowly, to prevent hemorrhage, a gum catheter being at the time in the bladder. The parts usually heal very rapidly.

After ablation of this organ the urine should be voided through a gum-elastic funnel, carefully fitted to the stump, otherwise, as it cannot be projected, it will fall upon the patient's feet, and even soil his clothes.

SECT. VI.—AFFECTIONS OF THE PREPUCE.

The prepuce is liable to various kinds of ulcers, warty excrescences, phimosis, paraphimosis, hypertrophy, and the formation of calculous concretions.

1. The *herpetic ulcer* is observed chiefly in young adults, on the inner surface of the prepuce, or at the junction of the skin and mucous membrane. It manifests itself by inflamed spots, of a bright-red color, varying in size from that of a millet-seed to that of a split pea. Small vesicles soon succeed, of a globular shape, remarkably transparent, agglomerated, and containing at first a serous, and subsequently a puriform, fluid. On the internal surface these vesicles lead to the development of thin, flat scales, which fall off about the fifth day, leaving a corresponding number of round, yellowish excoriations; on the external surface, rough, irregular scabs form. By running together, these ulcers occasionally form one unbroken sore, occupying nearly the whole of the prepuce. The disease is very apt to recur, and is usually attended with some itching, but rarely with pain. The exciting causes are friction, want of cleanliness, and disorder of the digestive organs. Persons of a delicate skin, and of a red complexion, are most liable to its attacks. The diagnosis between herpes and chancre is described in the chapter on syphilis.

The treatment consists in the use of a brisk purgative, and a light, cooling diet, with frequent ablutions of the affected surface, and the steady application of lint saturated with weak solutions of tannic acid, zinc, or lead, or with very weak yellow wash, as one-fourth of a grain of bichloride of mercury to the ounce of lime-water. Zinc ointment and the dilute ointment of nitrate of mercury are also excellent remedies. Dusting the part with calomel, and keeping it constantly covered with dry lint, often afford prompt relief. Mercury should never be used internally.

2. The *psoriasis ulcer* is most frequently met with in persons whose foreskin is unnaturally long, moist, and tender. It is an obstinate and painful disease, characterized by deep cracks, chaps, or fissures, on the edges of the prepuce, which becomes gradually thickened, hardened, and so corrugated as to occasion phimosis. The number of ulcers is sometimes very considerable; they are very tender and unseemly; are apt to bleed when injured; are extremely difficult to heal; and, if large, are attended with a copious, puriform discharge. Small, brownish-looking scales occasionally form on these sores.

Fig. 638.



Warts on the Penis.

The causes and treatment of psoriasis of the prepuce are similar to those of herpes. When the disease is unusually obstinate, slight ptyalism, maintained for several weeks, is sometimes necessary.

3. The penis, as seen in fig. 638, is liable to the development of *warty excrescences*, as a consequence, chiefly, of gonorrhœa, or of impure connection with females laboring under leucorrhœal and other discharges. Although they may occupy any portion of the organ, they are most common around the neck and at the side of the frenum, where they often occur in immense numbers, from the size of a pin-head up to that of a small hickory-nut; they are usually of a conical shape, with a rather small pedicle, rough, fissured, or tuberculated, of a firm consistence, of a bright florid color, and of a fibrous structure. When these vegetations are very numerous, they form a large tumor, or a series of agglomerated masses beneath the prepuce, discharging an abundance of horribly fetid pus. They frequently bleed on the slightest touch, and are always extremely prone to recur after extirpation.

The most effectual remedy for these warty excrescences, in their earlier stages, is chromic acid, applied with a piece of soft wood, their surface having previously been divested of moisture. Repetition is effected every third or fourth day, the parts being in the mean time frequently washed, and kept asunder by the interposition of dry lint, which is also one of the best means for preventing relapse. In the more simple cases, excellent results are produced by sprinkling the growths thoroughly twice a day with equal parts of subacetate of copper, tannic acid, and powdered savin. When the excrescences are very large and old, hardly anything short of excision will be likely to do any good. The operation is easily performed with the scissors, but is always very painful, and occasionally quite bloody. Dry lint is

applied after the bleeding has ceased, and the next day the surface is gently touched with chromic acid. If the patient object to the knife, a good substitute will be found in the Vienna paste, care being taken that its influence does not extend into the sound parts. When the repullulating disposition is very strong, recourse should be had to the use of iodide of potassium, with minute doses of bichloride of mercury, although, in general, constitutional means are unnecessary, if not useless.

4. *Phimosis*, fig. 639, consists in a contraction and elongation of the prepuce, attended with an inability to uncover the head of the penis. It presents itself in two varieties of form, the congenital and the acquired. In the first, the narrowing of the prepuce depends chiefly, if not exclusively, upon the short, tight, and undeveloped condition of the mucous membrane, the skin and cellular tissue being per-

fectly natural; in the other, all the structures are condensed by inflammatory deposits, the result usually of gonorrhœa, balanitis, chancre, or some other disease. However induced, the affection requires proper attention, as it always interferes with cleanliness and comfort, if not also with copulation. It has been supposed that, by retaining the irritating secretions of the sebaceous follicles, it might become an exciting cause of carcinoma of the penis and prepuce, an opinion, however, which does not seem to be well founded, as I have never met with an instance. In congenital phimosis, especially if long continued, the complete development of the penis is sometimes prevented by the pressure of the narrow and contracted prepuce; and another result not of uncommon occurrence is hyperæsthesia of the glans, leading, in young boys, to masturbation.

When the contraction is associated with unusual elongation of the prepuce, the proper procedure is circumcision. With this view, the redundant parts, steadied with a pair of slender forceps, applied obliquely immediately in front of the head of the penis, are cut off with one sweep of a long bistoury from above downwards and from behind forwards. Care should be taken to interfere as little as possible with the frenum. The contracted and tightened membrane is then, if necessary, divided with the scissors. Any little arteries that may bleed are secured with fine ligatures, when the muco-cutaneous edges of the wound are approximated with four sutures, placed at equidistant intervals. Elevation of the penis, with cold water-dressing, recumbency, light diet, and a purgative the morning after the operation, constitute the after-treatment. The sutures are removed at the end of the third day.

Fig. 639.



Phimosis.

When a person affected with phimosis is laboring under the hemorrhagic diathesis, the safest plan is to use the *écraseur*, or to include the redundant parts in a ligature, as, in such an event, the use of the knife might be followed by fatal bleeding.

When phimosis is unattended by elongation, relief may be afforded by slitting up the prepuce in front, along the middle line, over a grooved director, as far back as the posterior extremity of the glans, the edges of the wound being afterwards tacked together by several points of the interrupted suture, as seen in fig. 640. The angles of the flaps are gradually rounded off, assuming, ultimately, a very seemly appearance. Or, instead of this, the contracted structures may be divided, as suggested by Cullerier, at three or four points, with a delicate pair of scissors, the sharp blade of which is thrust into the connecting cellular substance, and carried as high up as the origin of the prepuce, while the blunt-pointed one glides harmlessly over the head of the penis. A more simple procedure, one which I have repeatedly practised, is to stretch and tear the mucous membrane with a pair of dressing forceps, and then to evert and turn back the prepuce, keeping it behind the corona until cicatrization has taken place. Circumcision performed according to the Hebrew rite is occasionally followed by fatal erysipelas, and I have heard of several cases in which death was caused by hemorrhage.



Operation for Phimosis.

The acquired form of phimosis often disappears of its own accord, or under the influence of sorbefacient applications, as mercurial ointment, saturnine lotions, or dilute tincture of iodine, and frequently-repeated pressure with the thumb and finger. When intractable, it must be treated upon the same principles as congenital phimosis; by excision, or excision and incision.

When phimosis is complicated, as it occasionally is from the irritation caused by the lodgment of sebaceous matter, with adhesions of the mucous membrane to the head of the penis, a long and tedious dissection may be required to sever the connections. In general, however, they are so slight as to yield readily under the pressure of the finger. The parts should afterwards be kept asunder by means of lint spread with cerate.

An adherent and elongated prepuce, especially if attended with a narrow orifice, is not unfrequently a cause of retention of urine, of difficult micturition, of incontinence of urine, and even of stone in the bladder. Sayre, Bryant, and Packard have reported cases in which such abnormalities gave rise to excessive sexual excitement, permanent priapism, and partial paralysis of the inferior extremities from reflex irritation, all promptly relieved by circumcision. The penis, in most of such cases, is short, thick, and stumpy, evidently from arrest of development.

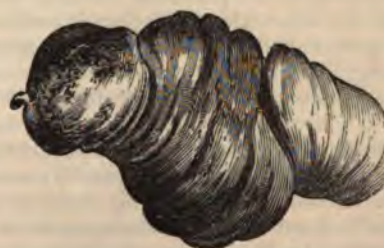
5. *Paraphimosis*, fig. 641, the reverse of phimosis, is a stricture just behind the head of the penis, caused by the retraction of the foreskin. When the constriction is very tight and protracted, it may produce not only violent suffering but mortification of the strangulated tissues. Even the milder forms of the affection, not

Fig. 641.



Paraphimosis.

Fig. 642.



Paraphimosis, the Parts being highly Inflamed and Swollen.

promptly remedied, generally give rise to great swelling, pain, and tenderness, owing to the copious deposits of fibrin and serum, especially the latter, which always arise within a short time after the occurrence of the displacement, as a con-

sequence of the resulting inflammation. These effects are well shown in fig. 642. The accident is most common in young boys who, in their eagerness to uncover the head of the penis, draw the prepuce forcibly back, and are afterwards unable to restore it to its natural situation. It may also arise during copulation and during the progress of various diseases of the penis.

The proper treatment in paraphimosis is to restore the parts as promptly as possible to their natural relations, which may always be done without difficulty soon

Fig. 643.



Reduction of Paraphimosis.

after the accident, but often not without great trouble, when severe inflammation and swelling exist. The proper procedure, in ordinary cases, consists in applying pressure to the head of the penis and the dislocated prepuce in opposite directions, by means of the thumbs and fingers, arranged in the manner exhibited in fig. 643. The best plan usually is to squeeze out the blood as thoroughly as possible from the turgid glans, before an attempt is made to push the prepuce forwards. Sometimes this object may be greatly facilitated, especially in recent cases, by pouring upon the part, from a considerable height, a steady stream of cold water. When the prepuce is hard and œdematous, the serum should be well drained off by numerous little punctures before any effort is made at reduction. When restoration is impracticable by the means now described, the strangulation should be relieved by a

small incision carried through the constricted skin, just behind the crown of the penis. The operation is generally as simple as it is effectual. Now and then, however, the surgeon is signally baffled, even when the parts are extensively divided at several points, as in the case of a lad, fourteen years of age, a patient at the College Clinic, in whom the paraphimosis had existed for ten days. The prepuce and head of the penis were much swollen and œdematous, and, although they had been thoroughly drained of serum, all the efforts I could employ proved unavailing, notwithstanding the system was completely relaxed by chloroform. Cold water-dressing for the first few days, and afterwards sorbefacient applications, will be necessary to place the parts in a healthy condition.

In recent cases of paraphimosis, the plan of Mr. Forster, of London, is worthy of trial. It consists in placing the patient upon his back, and then lifting him up bodily by grasping the penis firmly with the right hand behind the seat of the constriction. There is no danger in the operation, as the organ readily bears all the strain that can be thus applied, and the prepuce invariably slips forward into its proper place.

6. *Enlargement* of the prepuce, amounting sometimes to enormous deformity, is liable to occur; generally as a consequence of interstitial deposits from severe and long-continued inflammation, such as that which attends phimosis or paraphimosis, especially the latter. Occasionally a good deal of serum accompanies the plastic effusion, giving the parts a pale, rose-colored, œdematous aspect, and readily admitting of pitting under pressure. When the new formation becomes organized, as it is apt to do when the irritation is protracted, the prepuce may acquire a most unnatural bulk, causing great deformity, and seriously interfering with, if not entirely preventing, copulation.

The treatment, in the milder forms of the affection, is sufficiently simple, being limited, in great measure, to the use of sorbefacient applications, as dilute tincture of iodine, or a weak solution of hydrochlorate of ammonia, aided by frequent punctures, to facilitate drainage, especially when there is much distention from serous deposits. Sometimes strapping answers a good purpose. When the enlargement is unusually great and firm, or presents the characteristics of a genuine hypertrophy, incommoding by its weight and bulk, the only feasible procedure is retrenchment with the knife or *écraseur*.

7. When the prepuce is very long and narrow, it may act as a receptacle for *calculus concretions*, of which some very curious examples are upon record. They are usually composed of uric acid, and vary in size from a mustard-seed to that of an almond. Their shape is spherical, or ovoidal, their surface rough or smooth, their

color grayish or pale ash. They are formed directly from the urine, which, owing to the difficulty of its escape through the narrow orifice of the prepuce, deposits its salts in the abnormal pouch, which is always more or less hypertrophied.

These concretions sometimes exist in extraordinary numbers. Thus, in a specimen in my possession, presented to me by Dr. John G. Kerr, of Canton, China, there are not less than one hundred and three, varying from the volume of a pin's head to that of a pea, their aggregate weight being two drachms. In another specimen, removed by the same gentleman from a man forty-five years old, there is a solitary calculus, closely resembling, in size and shape, the head of the penis. The affection seems to be common at Canton, as Dr. Kerr met with six cases of it in one year. Persons thus affected are of course unable to copulate.

Dislodgment of these bodies is always readily accomplished by incision of the prepuce. If the parts are greatly hypertrophied, the necessary retrenchment is effected immediately after the extraction.

8. *Hypertrophy* of the prepuce, or of the prepuce and penis, is occasionally observed, principally in the form of elephantiasis. In the latter event, it is generally associated with elephantiasis of the scrotum. The disease, which sometimes commences at an early period of life, is most frequently met with in the inhabitants of warm climates, and may proceed to such an extent as to occasion not only great deformity but complete impotence. In a case related by Wadd, the organ was fourteen inches in length by twelve inches and a half in circumference. The skin is usually very rugose, hard, thick, and insensible; the areolar tissue is changed into a dense fibroid substance; and the cavernous bodies and head of the penis are abnormally large, as well as increased in consistence. Micturition is generally sufficiently easy, and the patient is sometimes able to command erections, even when the organ has acquired an enormous bulk.

The only remedy for this affection, in its more advanced stages, is excision, performed in such a manner as to save, if possible, a sufficiency of skin for the denuded organ. When the disease is in its incipency, it may sometimes be arrested by a mild mercurial course and by sorbefacient applications.

9. *Nævus* of the prepuce is of rare occurrence, and exhibits no peculiarities entitling it to special notice. When of long standing, it may form a tumor of considerable bulk, involving the head and body of the penis, and thus greatly complicating the case. The only instance of *nævus* of the prepuce with which I have met occurred in a gentleman forty years of age, who consulted me on account of a growth of this kind, as large as an almond, situated at the junction of the skin and mucous membrane. It had existed from an early period of his life, and was a cause of sexual incapacity. Ablation was readily effected with the knife, only a few small vessels requiring ligation. When such a tumor is of inordinate size, or involves both prepuce and penis, it should be removed with the *écraseur* or ligature, as a safer means than the knife.

10. The prepuce is occasionally *cleft* longitudinally, as a congenital defect, the opening extending from its base to its extremity. The edges of the fissure are red and callous, and separated at a variable distance. When the flaps are large, the best plan is to refresh and to unite them by suture, as in the operation for harelip, otherwise they should be retrenched, especially if they interfere with copulation.

11. The *frenum* of the prepuce is sometimes at fault. Thus a person may be much annoyed by its excessive shortness. The defect, which is generally congenital, may interfere with the retraction of the foreskin, and even with copulation, by drawing the head of the penis downwards and backwards, especially when the attachment of the part extends as far forwards as the urinary meatus. The proper remedy is division.

Several cases have fallen under my observation in which great vexation was experienced in consequence of the destruction of the frenum by disease or accident. In one of my patients the suffering thus produced amounted almost to monomania. When the case assumes such importance as this, an attempt may be made to remedy the defect by an operation similar to that for harelip, the contiguous surfaces of the prepuce and head of the penis being carefully pared and accurately kept together by means of the twisted suture. In the instance above mentioned the result was highly gratifying.

SECT. VII.—GONORRHOEA.

Gonorrhœa is an inflammation of the mucous membrane of the urethra, produced by the contact of a specific virus. This virus, as has been established by numerous experiments conducted in the most careful and unexceptionable manner, has no properties whatever in common with that of syphilis, notwithstanding it was at one time supposed that they were identical, or, if not absolutely identical, at all events, under certain circumstances, convertible, as it respects their effects. The test of inoculation, however, has thoroughly dispelled this delusion, which could only have had its origin in the fact of the occasional coexistence of gonorrhœa and chancre.

Of the essential nature of the virus of gonorrhœa nothing is known; all that has been ascertained respecting it is that it resides in the purulent matter which its presence excites during the existence of the specific inflammation, and that it requires a mucous surface for the development and display of its peculiar action. Placed in contact with the cutaneous tissue, or with any other tissue than the mucous, it is incapable of producing any other effect than ordinary pus; the part, it is true, may slightly inflame, and even suppurate, but the fluid thus derived possesses none of the properties of gonorrhœal matter, and is, therefore, wholly innocuous. The disease to which it gives rise is strictly of a local nature, being exclusively limited in its action to the mucous membranes, especially those of the genito-urinary organs, and has the faculty of gradually wearing itself out, or of disappearing spontaneously. In all these respects, as well as others that will hereafter be mentioned, it differs essentially and characteristically from the poison of syphilis, which is capable, not only of producing a severe local disease, but also of contaminating the whole system, the blood as well as the solids, and of thus engendering a diathesis which is transmissible from the parent to the offspring. How long the virus of gonorrhœa retains its infectious properties, after it has awakened the specific inflammation, is a question which has not been satisfactorily settled; much will, doubtless, depend upon circumstances, the period being comparatively short in some cases, and the reverse in others.

The poison of gonorrhœa, as already stated, is capable of producing its specific effect only upon the mucous tissues, and its predilection for the genito-urinary mucous surfaces is well known. In the male, the parts usually affected are the urethra, the head of the penis, and the inner surface of the prepuce; in the female, the lining membrane of the vulva, vagina, and uterus, is most liable to suffer, the urethra often escaping entirely, even when the attack is of more than ordinary severity. In both sexes, the disease, in consequence of direct inoculation, occasionally attacks the anus, the nose, and the conjunctiva, frequently destroying the sight in less than twenty-four hours from the commencement of the morbid action.

The period of latency of the gonorrhœal poison, or the interval which intervenes between the impure connection and the development of the disease, probably does not exceed a few hours, although from three to five days usually elapse before it exhibits any well-marked symptoms. Occasionally, however, the peculiar discharge shows itself as early as six, twelve, or fifteen hours, and, on the other hand, cases are seen where it does not appear before the expiration of a week or more. There is great diversity, in this respect, in different individuals, some being extremely susceptible to the impression of the virus, while others are almost proof against its attacks in any event. Young men with a large orifice of the urethra, and a tender, delicate skin, with a predisposition to herpetic affections of the cutaneous and mucous tissues, are particularly liable to suffer. A long and narrow prepuce, entangling and retaining the virus, is another circumstance favoring the development of the disease. One attack of gonorrhœa is no protection against another. Some men literally labor habitually under the disease; no matter what precaution they may employ, they can not have intercourse without being inoculated. They contract the affection as easily as tinder catches fire. The smallest spark of virus is sufficient to kindle the disease.

Dr. Le Fort, of the Midi Hospital of Paris, finds that of 2583 cases of gonorrhœa, the disease in 778 appeared within the first four days, in 869 from five to eight days, in 276 from nine to twelve days, in 112 from thirteen to sixteen days, and in 17 from seventeen to twenty days. The first signs in 50 cases of the disease were observed at the end of twenty-four hours, in 149 after the second day, and in 327 after the

third day. In only 35 of the entire number of cases did the incubation exceed the fifteenth day.

Symptoms.—Gonorrhœa may, practically considered, be regarded as consisting of three stages, each of them marked by a certain train of phenomena, giving them a sufficiently distinctive character. The first may be called the formative stage, the second the stage of maturity or full development, and the third the stage of decline.

The first stage, comprising the initiatory steps of the disease, is announced, as its very first symptom, by a sense of titillation along the course of the urethra, especially at its anterior extremity, and by a feeling of turgescence and weight in the penis. Shortly after this the orifice of the tube is observed to be red and pouting, and glued up with a thin, whitish secretion; the head of the penis has a swollen and phlogosed appearance; some degree of scalding is experienced in voiding urine; and, upon pressing the urethra, a small quantity of watery mucus may be squeezed out. The fluid is merely an increase of the natural secretion of the part; it is somewhat viscid, although hardly as much so as in health, and, if any of it fall upon the patient's linen, it is very apt to leave a little darkish stain, the spot feeling slightly stiff.

The first stage seldom lasts beyond a day or two, occasionally, indeed, not more than a few hours, when it is succeeded by the second. The fire, previously kindled, now bursts forth in a full flame, and the disease soon reaches its acme. Every symptom is declarative of inflammatory action. The discharge is now quite abundant, often amounting to several drachms in the twenty-four hours; of a thick, ropy, cream-like consistence, and of a light-yellowish color, generally bordering upon greenish. In case the morbid action runs very high, it is not uncommon for the pus to contain more or less lymph, thereby augmenting its consistence, and also pure blood, the result, probably, of a rupture of some of the minute vessels of the mucous membrane. The whole penis is very much swollen, tender, and painful, its head being extremely red and congested, and the prepuce enlarged and œdematous; the scalding in voiding urine is violent, and the stream is often much diminished in size; there is a frequent disposition to erections; and the system, sympathizing with the local disorder, is feverish and uncomfortable. When the inflammation is of extraordinary severity, there is apt to be serious involvement of the neighboring parts, along with soreness of the testicles, groins, and perineum, and tumefaction of the veins and lymphatics of the back of the penis.

These symptoms may last for several weeks, and they will be very apt to do so unless combated by appropriate means. Sometimes they subside under very simple treatment; at other times, and more generally, active measures are required for their subjugation. As the inflammation abates, the discharge not only diminishes in quantity, but changes in quality, becoming small, thin, and pale, resembling weak whey, or a thin mixture of mucus, or mucus and pus, in water. Occasionally it is of a thin, turbid nature, or slightly sanguinolent, leaving a characteristic stain upon the patient's linen. There is now comparatively little scalding in micturition; the stream of urine is also more bold; and there is less tendency to morbid erections. The disease, in fact, is in a subacute state; it has lost its severity, and is manifestly on the decline, subject, however, upon the slightest exposure, or from the most trifling irregularity, to a resumption of all its former intensity. In this way it may flow and ebb, now advancing and now receding, for weeks and even months, without any apparent indication as to a final cure. Having reached this point, the term chronic is applied to it, or, as expressive of the nature of the discharge, the word *gleet*, the fluid being of a thin, whitish character, small in quantity, and but little different from the natural secretion, unless it is temporarily changed by a reaccession of inflammation. It is generally somewhat viscid, and hence it is apt to glue together the edges of the orifice of the urethra, particularly in the morning and after exercise. The quantity of fluid sometimes does not exceed a few drops in the twenty-four hours; at other times it is more considerable, and then leaves, perhaps, several distinct marks upon the patient's linen. Occasionally almost the only discharge is a whitish, flaky substance, looking very much like little fragments of soft-boiled rice, which is sure to cause the patient a great deal of anxiety, and the surgeon no little annoyance.

There is a form of gonorrhœa in both sexes, in which, instead of the usual discharge, the parts are remarkably free from moisture, constituting what the older writers were in the habit of calling *gonorrhœa sicca*, or dry clap. It is character-

ized by a high degree of scalding in micturition, excessive soreness and tenderness in the penis and circumjacent parts, and by a great tendency to morbid erections, the inflamed surface being uncommonly red and congested. The dryness rarely continues beyond a day or two, when it is generally succeeded by an abundant, greenish, muco-purulent discharge, not unfrequently intermixed with pure blood, indicative of the intensity of the morbid action.

Pathology.—Gonorrhœa is essentially, from first to last, an inflammation of the mucous tissue of the urethra, the intensity of its action varying in the several stages into which the disease is usually divided. The primary impression is generally made upon the anterior portion of the canal, not occupying, perhaps, more than a few lines of its surface, but as it advances it gradually and sometimes rapidly extends over the greater part of the lining membrane, reaching as far back as the neck of the bladder, and forwards to the head of the penis and even to the prepuce. Although few opportunities have been afforded of inspecting, after death, the urethra of persons affected with acute gonorrhœa, yet enough has been learned to show that, when in this condition, its mucous membrane is of a red, florid complexion, from the injection of its capillary vessels, most distinct about the navicular fossa and the bulb, and that there is marked enlargement of its follicles, especially of the lacunæ of Morgagni, which, from their great size in the natural state, would often seem to be obliged to bear the chief burden of the disease, the morbid action frequently lingering here long after it has ceased in the other structures. A knowledge of this fact is of no inconsiderable practical importance, as it serves to explain the astonishing obstinacy which, in many cases, characterizes gonorrhœa, depending apparently upon the difficulty of medicating the interior of these follicles, owing to their depth and peculiar position, rendering it difficult to force injecting matter into them.

In addition to the above appearances, it is usual to find considerable thickening of the mucous membrane, thus accounting for the diminished size of the stream of urine; and, in the more violent forms of the disease, there is always inflammatory new formation in the cells of the spongy substance of the urethra, causing that peculiar incurvation of the penis which attends its morbid erections. When the gonorrhœa extends far back, the glands of Cowper are liable to be involved, and it is well known that the prostate gland, the neck of the bladder, and, in fact, the whole seminal apparatus, not unfrequently suffer, especially when the disease continues uncommonly long in a very active condition. It was formerly supposed that such an amount of discharge as generally attends specific inflammation of the urethra was closely connected with an ulcerated condition of its mucous membrane, but dissection has proved that this is not the case; it is only when gonorrhœa is associated with chancre of this canal, a very rare event, however, that such an occurrence is at all likely to happen.

In chronic gonorrhœa, commonly called gleet, the mucous membrane, from the bulbous to the prostatic portion of the urethra, is studded, as may be shown by endoscopic inspection, with numerous granulations, of a florid color, and of a soft, spongy consistence, similar to those so often observable in chronic inflammation upon the conjunctiva, larynx, fauces, vagina, and uterus. Not unfrequently, indeed, the granulations are spread over the entire surface of the tube. The discharge is generally thin and watery, and is most abundant in the morning, after strong sexual excitement, and after the use of stimulating food and drink.

Complications.—Gonorrhœa may exist in a very simple form, passing through its different stages without infringing in the least upon any tissues save those primarily and necessarily implicated. In general, however, it encroaches more or less upon the surrounding structures, thus producing those more severe and distressing symptoms which so often characterize the lesion. These secondary affections, or complications, as they may be termed, coming on at a variable period during the progress of the inflammation, are balanitis, chordee, cystitis, retention of urine, epididymitis, bubo, hemorrhage, chancre, phlebitis of the penis, and abscess of the urethra, perineum, and prostate gland.

Gonorrhœa of the urethra occasionally coexists with gonorrhœa of the head of the penis and prepuce, known under the name of *balanitis*, from a Greek word signifying gland. The two affections may arise simultaneously, or one may take precedence of the other, and they may go on together for an indefinite period, although the latter generally disappears long before the former, as it is much more amenable

to medication than the disease of the urethra. The reason why the gland does not always participate in the inflammation of the canal is simply because, from its constant exposure and consequent hardness, it loses, in great measure, its susceptibility to morbid impressions. What corroborates this statement is that balanitis, spurious, or preputial gonorrhœa, as it is variously termed, is almost exclusively confined to young subjects with a long, narrow, and very sensitive foreskin. An infection of such a nature is almost unknown in the Israelite, who, in obedience to the requirements of the rites of his church, is compelled to part with this cutaneous appendage at the end of the first week after his birth.

The disease is usually well marked from its commencement, the prominent symptoms consisting of more or less pain and itching, along with a discolored and abraded appearance of the inflamed surface, marked tumefaction of the prepuce, which is often quite œdematous, and an abundant puriform discharge, of a peculiarly fetid and irritating character, apparently from the admixture of sebaceous matter, which is always so copiously secreted in this disease. The morbid action is especially severe along the gutter behind the crown of the penis, at the point of reflection of the prepuce, depending upon the remarkably delicate, vascular, and glandular structure there.

The diagnosis is always very easy when the patient is able to retract the foreskin, but when this covering is unusually narrow it is often very difficult, if not impossible, to determine the precise source of the discharge, as it may then proceed entirely from the urethra, or partly from the urethra and partly from the head of the penis. The principal signs of distinction are, the smaller amount of pain and scalding in micturition in balanitis than in urethral gonorrhœa, the more profuse discharge, the more severe swelling, the slighter tendency to chordee, and the more tractable character of the malady. The discharge may proceed from a concealed chancre, but in this case it will not only be thick, but very abundant, and there will, besides, be a circumscribed hardness, easily distinguishable by the touch.

Chordee is extremely common, and is generally a source of great distress; it is never absent during the height of the inflammation, and is always most severe at night, when the patient becomes warm in bed, or the mind is engaged upon a lascivious dream, an unchaste image, or an impure thought. Its attacks are variable; it often comes and goes several times during the night, and, not unfrequently, it lasts for hours together, causing sleeplessness and excessive pain, the more so because it is entirely involuntary, the organ refusing to be controlled by any effort of the will. In the more violent forms of the disease, it is attended with a remarkable incurvation of the penis, the organ being bent backwards towards the perineum, by the distention of the cells of the erectile structure of the urethra by inflammatory new formations, thus preventing the influx of blood necessary to the erection of the affected tissue. When the distention is unequal, the penis is sometimes drawn to one side. Occasionally the cavernous bodies suffer in a similar manner, although in a less degree.

Cystitis, as a complication of gonorrhœa, is caused by an extension of the inflammation from the urethra to the bladder, along the mucous membrane, affording thus an example of the propagation of disease by continuity of structure. It often supervenes at an early stage of the morbid action, and forms an exceedingly disagreeable concomitant, being characterized by an almost constant desire to urinate, by heat and pain deep down in the pelvis, and by a sense of burning or scalding in micturition, especially at the close of the operation. The inflammation is confined, in great measure, to the neck of the bladder. When very severe, it may be accompanied by a discharge of puriform matter, or even pure blood.

In consequence of the inflammatory irritation of the urethra and neck of the bladder, such an amount of spasm may be produced in the latter organ as to give rise to *retention of urine*. The affection is characterized, in addition to the symptoms ordinarily present in this condition, by excessive burning and smarting along the course of the urinary passages, and by a great deal of soreness and tenderness in the perineum and anus.

The immediate cause of *epididymitis* generally is a repulsion of the gonorrhœal inflammation, from exposure to cold, or the use of irritating injections, the period at which it supervenes being liable to much diversity. Thus, of 645 cases, observed by Dr. Le Fort, of Paris, 24 occurred during the first week; 93 in the second week; 182 from the fifteenth to the thirtieth day; 150 between the first and second month;

42 between the second and third month; 26 after the third month; 14 after the fourth month; and 25 after the sixth month. Although the disease commonly begins in the epididymis, it rapidly extends to the body of the testicle, so that the two may be said to be implicated nearly in an equal degree. The swelling and other symptoms are well marked, and the suffering is often intense, the system frequently deeply sympathizing with the local disorder. The original seat of the inflammation is the mucous lining of the seminal passages, but it is almost invariably limited to one testicle. Thus, of 138 cases, collected by Gaussail, D'Espine, and Curling, both organs were affected only in 11. Of the remaining cases, the right testicle was the seat of the disease in 78, and the left in 49. Le Fort found it double in 44 cases out of 540. During the height of the inflammation, and sometimes even at an early period, there is almost always a suppression of the gonorrhœal discharge.

Bubo is an occasional sequence of gonorrhœa; it is most liable to form in young subjects, after exposure to cold, or severe fatigue, and is usually confined to one groin, the lymphatic glands of which become enlarged, tender, and painful, but rarely suppurate. The swelling may be seated above Poupart's ligament, but, in a majority of instances, it will be found below, the number of glands concerned varying from one to three or four.

Hæmorrhage of the urethra, as an attendant upon gonorrhœa, is an uncommon occurrence; it generally takes place during a violent erection, from rupture of some of the vessels of the mucous membrane, and may be so considerable as to require active measures for its suppression. There is nothing definite as to its seat, although generally it will be found to be located in front of the pubic portion of the canal.

The coexistence of gonorrhœa and *chancre* of the urethra is probably more common than is generally imagined, and it was this circumstance, no doubt, which led to the notion, at one time so common among surgeons, of the identity of the two diseases. As this subject, however, has received due attention in the chapter on syphilis, all that is here necessary is to state that the chancre is usually situated in the anterior extremity of the canal, immediately within, or a little beyond, the meatus, where its presence is always indicated by a circumscribed hardness, and, not unfrequently, by all the visible signs of an ulcer.

Phlebitis of the penis, as a complication of gonorrhœa, is very uncommon. It generally sets in within the first two or three weeks of the disease, and is characterized by the existence of a hard, firm cord, situated in the course of the dorsal veins. The pain is usually considerable, and there is nearly always some degree of œdema. No constitutional symptoms attend.

Finally, gonorrhœa is occasionally productive of *abscesses* in the submucous or subcutaneous cellular tissue of the urethra, preceded by the ordinary phenomena of inflammation, and pointing in various situations, sometimes along the spongy portion of the tube, sometimes in the perineum, and sometimes, again, in the region of the prostate gland. Such an occurrence, which, fortunately, is uncommon, is most liable to happen in persons in whom the specific disease is coincident with stricture of the urethra, leading to great difficulty in micturition.

Such is a brief account of the more common and more immediate consequences of gonorrhœa; to complete the history of this part of the inquiry, it is necessary to add that the disease often leads to stricture of the urethra, owing to the protracted inflammatory action of the mucous membrane, and the inevitable effusion of plastic matter into its substance. There is reason to believe, as has been stated elsewhere, that this lesion is much more frequently produced by gonorrhœa than by all other causes combined.

Besides the local effects of gonorrhœa now considered, there are others which are of a general character, and which may, therefore, be said to be *constitutional*. The affections which are usually described as belonging to this category are gonorrhœal rheumatism, ophthalmia, and cutaneous eruptions, more especially some of the scaly forms. These affections are, it would seem, remarkably common in London, in consequence, as is supposed, of the damp, cold, and variable state of the atmosphere so prevalent in the British metropolis. In this country their occurrence is extremely infrequent, and as I have never witnessed any instances of them, either in hospital or private practice, I am strongly inclined to the opinion that their existence is in great degree imaginary. I have certainly seen enough cases of gonorrhœa to justify me in believing that, if these secondary affections were of such common occurrence as they are represented to be, instances would occasionally have fallen under my

observation, and thus have afforded me an opportunity of studying their history. But no such opportunity has occurred, and I am, therefore inclined to regard the super-vention of these so-called secondary affections, not as a result of the direct action of the gonorrhœal poison upon the system, but as a mere coincidence, taking its place in a constitution strongly predisposed, by hereditary influence, atmospheric vicissitudes, and the debility occasioned by the treatment of the original disease, to the development of rheumatism in various parts of the body, particularly the joints, muscles, and sclerotic coat of the eye. I cannot, indeed, conceive how the subject can be viewed in any other light. All pathologists are agreed that gonorrhœa is strictly a local malady, and that the poison produced by it, although it may be absorbed into the system, is incapable of contaminating the solids and fluids, in the sense in which this question is regarded when the poison of chancre has been conveyed into the body. If gonorrhœa is a constitutional disease in one case, it ought to be so, as a general rule, in all, the same law holding good here as in syphilis, and yet every one knows that this is not true. In warm climates and intertropical regions nothing is ever heard of gonorrhœal rheumatism, whereas syphilis, in its secondary and tertiary forms, is unusually rife. The fact seems now to be well established that at least some of the forms of so-called gonorrhœal rheumatism are only mild forms of purulent infection.

Scaly eruptions of the skin, and soreness of the throat, probably depend upon the absorption of chancreous matter, and not upon any malign agency exerted by the poison of gonorrhœa. This view of the subject appears the more plausible, when it is remembered that these consecutive affections of the cutaneous and mucous tissues are well-known results of syphilis, especially of the milder forms. It is only necessary to suppose, what, indeed, so often happens in venereal diseases, that the patient is simultaneously affected with gonorrhœa and chancre, or that the latter malady has somewhat preceded the former, and all the difficulty with which the subject is invested will at once vanish.

Gonorrhœal *ophthalmia*, described in a previous chapter, presents itself in two varieties of form, the conjunctival and sclerotic. The former, when the result of direct inoculation, is a most painful and destructive disease, generally speedily eventuating in gangrene of the cornea and loss of sight. Gonorrhœal scleritis is comparatively infrequent; it is a constitutional affection, which commonly coexists with rheumatism in other parts of the body, particularly of the joints, and is characterized by the usual phenomena.

Pyæmia, as the result of gonorrhœa, occurs chiefly, if not exclusively, in subjects of an anemic, broken-down constitution. The disease appears at a variable period after the commencement of the discharge, and is characterized by the ordinary phenomena, as rigors, followed by high fever, excessive prostration, aching of the limbs and back, and an icterode condition of the skin. Dissection reveals congestion of the internal viscera, with metastatic abscesses, purulent deposits in the joints, and inflammation of the prostatic, vesical, and pelvic veins.

Fournier has described a rare form of *sciatica*, attributable, as he supposes, to the effects of gonorrhœa. The disease usually commences quite suddenly, speedily reaches its maximum of intensity, and seldom lasts longer than five or six days. It differs from ordinary sciatica by the rapidity of its course, the severity of the pain, and the readiness with which it yields to cupping and veratria ointment.

Treatment.—In the treatment of gonorrhœa it is important not to lose sight of the several stages into which it is usually divided, as they must necessarily exert a modifying influence upon the employment of our therapeutic measures.

There seems to be a general belief that an incipient gonorrhœa may, if properly managed, be cut short, or be made to abort. A course of treatment, consisting principally of injections, aided by repose and light diet, and bearing the imposing name of *ectrotic*, has, accordingly, been devised and much insisted upon as almost, if not completely, infallible. The article, serving as the basis of this medication, is nitrate of silver, in the proportion of a quarter of a grain to the ounce of water, and thrown up every four hours for two successive days, unless it be found that the discharge assumes a thin, sero-sanguinolent character, the natural effect of the remedy, when it is to be discontinued sooner. The intention of this treatment, which, we are told, should be conjoined with perfect rest, abstinence from animal food, and the use of diluent drinks, is to subvert the specific inflammation, before it is fully developed, by the substitution of one of an entirely simple character.

Another plan, the very opposite of the above, so far as the local measure is concerned, and of British origin, proposes to attain the same end by the use of a strong solution of nitrate of silver, containing at least ten grains of the salt to the ounce of water, and introduced once a day, until there is unequivocal evidence of a complete change in the nature of the morbid action. The credit of this suggestion is, I believe, usually ascribed to the late Dr. Wallace, of Dublin.

I allude to these two modes of practice merely for the purpose of condemning them, being satisfied, from ample experience, that, although they may sometimes succeed in arresting the disease in its incipency, yet, in general, they either completely fail, or, what is worse, only aggravate the existing trouble, increasing the discharge, pain, and scalding of the urethra, protracting the attack, and endangering the safety of the epididymis and testicle. A much more rational, because a much safer, plan, is to treat the disease, in this stage, with the mildest possible injections, consisting of a very weak solution of acetate of zinc or lead, in water, the quantity of the salt not exceeding the fourth or third of a grain to the ounce. This may be thrown up three times a day, and often exercises a remarkably controlling influence over the disease. Or, instead of this, an injection of two grains of tannic acid to the ounce of water may be employed several times in the twenty-four hours. Finally, I frequently use, with the happiest effect, as an injection, in this stage of the disorder, simple tepid water, green table tea, or some mucilaginous fluid, mixed with a few drops of laudanum. I have myself always found that the more mild and soothing the treatment is during the incubative period the more likely it will be to prove beneficial in arresting the disease, and this is a point upon which it is impossible to insist too strongly with the young and inexperienced practitioner, who is too apt to commit the very serious mistake of employing harsh remedies where those of an opposite kind alone are admissible. Along with these means it is important that the patient should be kept perfectly quiet, abstaining from meat, condiments, and all stimulating articles of food and drink; that free use should be made of cooling drinks, and that the parts should be well fomented with cloths wrung out of warm water.

In the second stage, when the disease has become fully established, as denoted by the excessive discharge, the pain and scalding in passing water, and the phlogosed condition of the penis, the treatment must be essentially antiphlogistic, precisely as in any other severe inflammation. The practitioner must lose sight entirely of the specific character of the disease, and look upon it in the light solely of a common affection. If the patient is young and plethoric, he should be bled freely at the arm, and immediately after take a brisk purgative; he should then be subjected to the exhibition of antimonial and saline preparations, repeated at such intervals and in such doses as shall maintain slight nausea and a gentle action on the bowels; perfect repose of mind and body must be enjoined; the diet must be very mild and restricted; and the urine should be rendered as bland as possible by the use of cooling drinks, which need not, however, be demulcent, as they do not possess any special advantage over simple water. If chordee proves troublesome, a full anodyne is given at bedtime.

The local treatment is of the most gentle kind. The complaining organ is placed in an easy, elevated position, and frequently immersed, for half an hour at a time, in a tincupful of tepid water, containing a teaspoonful of common salt, the object being not only to soothe and relax the parts, but to promote cleanliness. If the pain and swelling be considerable, the genitals, together with the hypogastrium and perineum, are kept constantly wet with cloths wrung out of hot water, either simple or medicated with laudanum or hops, and covered with oiled silk. Under similar circumstances, leeches are sometimes serviceable, from fifteen to twenty being applied to the groin, pubes, and perineum, the flow of blood being afterwards promoted by the ordinary means. The only direct medication during this period is an injection of tepid water, repeated from six to ten times in the twenty-four hours.

This treatment need seldom be continued longer than three or four days, even in the most severe forms of the disease; at the end of this time the inflammation is generally sufficiently subdued to justify the employment of what are usually considered, and not without reason, as the specific remedies for this disorder. These are the copaiba and cubeb, the efficacy of which in relieving gonorrhœa has long been thoroughly established. By many practitioners, indeed, these articles are habitually employed without any preparation whatever, either of the part or system,

in all stages of the affection, from its first inception to its final termination in gleet. That this treatment occasionally succeeds is indisputable, but more frequently, by far, it allows the disease to go on unrestrained for an indefinite period.

The dose and mode of administration of *copaiba* deserve consideration. Many persons readily bear a drachm, three times a day, but a smaller quantity than this generally makes nearly as strong an impression upon the disease, while it is much less liable to disturb the stomach and bowels, and to cause eruptions of the skin. Indeed, I have often found that a third or fourth of a drachm will answer every purpose. The most eligible form of exhibition is that of emulsion, prepared by rubbing the balsam up in gum Arabic and extract of licorice, to which are afterwards added camphor water and spirit of nitrous ether, with a little tincture of opium. The camphor water is a valuable ingredient on account of its soothing effects upon the genito-urinary apparatus, and may be administered three times daily, in quantities varying from two to four drachms. The dose of nitrous ether should not exceed ten or twelve drops, as only the slightest possible impression upon the renal secretion is aimed at. When the *copaiba* causes acid eructations, nausea, griping, or diarrhoea, a minute portion of morphia, or a few drops of acetated tincture of opium, may advantageously be combined with it. As camphor water is not always agreeable, a good substitute may generally be found in cinnamon, mint, or ginger water. When there is much scalding in voiding urine, or an unpleasant eruption of the skin, a few grains of bicarbonate of soda may be added to each dose of the mixture, or, what is preferable, the free use of alkaline and demulcent drinks may be enjoined. The licorice is particularly valuable in disguising the taste of the *copaiba*. The oil of gaultheria, one drop to the ounce of emulsion, is often employed for the same purpose.

When the *copaiba* emulsion disagrees with the digestive organs, it is occasionally administered by the rectum, as an injection, but such a mode of medication is not only very inefficient, but extremely disgusting, and has, therefore, found little favor. Under similar circumstances, the *copaiba* capsule is often used, the balsam being thus conveyed, without coming in contact with the gustatory nerves, into the stomach, where, its envelop being dissolved by the gastric juice, it soon enters the circulation, producing an effect like that which results from the use of the emulsion, although less rapid, and, on the whole, also, less beneficial. It is for this reason, therefore, that the fluid preparation deserves a decided preference. The ordinary dose of capsules is two thrice a day. There is a preparation of *copaiba*, formerly much in vogue, but now very justly discarded, on account of its inertness, consisting of a combination of this article with carbonate of magnesia, administered in pill form.

When *copaiba* disagrees, it may sometimes be advantageously replaced by *cubebs*, or the two articles may be used in combination, experience having shown that the modifying influence thus produced occasionally enhances their beneficial effects, at the same time that it renders the stomach more tolerant of their presence. The usual dose of powdered *cubebs*, the only form in which they are administered in gonorrhoea, is one drachm, three times daily, in a little milk, but twice and even thrice this quantity may be given without detriment. In fact, it generally requires rather a large dose to produce any marked effect at all.

Of the two articles here mentioned as the great antigonorrhoeal remedies, the advantages are, in every respect, greatly in favor of the balsam of *copaiba*, especially when perfectly pure, and given in the form of camphor emulsion. What its mode of operating is, or how its remedial effects are produced, is solely a matter of conjecture. It is positively certain, however, that it makes a direct impression upon the affected surfaces, as the odor of the balsam is always very apparent in the urine, even if used only for a short time. *Cubebs* also exert a direct influence upon the genito-urinary mucous membrane, but the benefit thus arising, both immediate and remote, is, as just stated, much less conspicuous than that of *copaiba*.

Along with *copaiba*, or *copaiba* and *cubebs*, direct medication must be employed; for the time has now arrived when *injections* are not only useful, but, in some degree, indispensable in order to corroborate and confirm the cure. A numerous catalogue of articles is at the command of the surgeon, from which to make his selection. The most valuable are the different preparations of lead and zinc, sulphate of copper, nitrate of silver, iodide of iron, alum, bichloride of mercury, and tannic acid, dissolved in soft water, and employed, either alone or variously combined, to suit the

exigencies of each particular case. The great rule with regard to their use is to begin with a very weak solution, the strength being gradually increased as the inflammation subsides, and the urethra becomes more tolerant to the effects of medication. Unfortunately, the opposite of this practice is too often adopted, and the consequence is that the foundation is thus but too frequently laid for organic stricture and other serious results, as troublesome to manage as they are distressing and alarming to the patient. A little skill and judgment will usually enable us to avoid this error; for, after all, the proper regulation of injections in the treatment of gonorrhœa is as much a matter of common sense as of a chastened experience. Another excellent practical precept in relation to this class of remedies is to vary their employment frequently, substituting one article for another as the former loses its effects, and also reducing or increasing their strength in proportion as they prove either too mild or too severe. I know of no branch of surgery where a practitioner may show his knowledge and judgment, in the treatment of disease, to more advantage, or in a more favorable light, than in that of gonorrhœa. Sometimes the very best injection, in this stage of the affection, is a grain each of acetate of lead and zinc to the ounce of water. Another article which I much employ is the iodide of iron, from one-fourth of a grain to half a grain to the ounce of water. The proper strength of the solution of nitrate of silver is from the fourth of a grain to two grains to the ounce of water; of sulphate of copper one-eighth of a grain; of tannic acid two to four grains; of alum from one to five grains.

Much of the success of an injection depends upon the manner in which it is administered. In the first place, the syringe should be good; large enough to hold at least two ounces, with a well-working piston, and a long, smooth nozzle. The patient sitting on a chair or the edge of the bed, inserts the instrument, charged with the lotion, deep into the urethra, the penis being held perpendicularly, and the edges of the meatus firmly pressed against the tube. The fluid is then sent back with some degree of force, so as to reach, if possible, the posterior extremity of the canal, in which it is retained for several minutes before it is allowed to escape. There is no danger of the injection passing into the bladder, or of its causing any harm, if it should do so, as its active ingredients would soon be neutralized by the urine, which, however, should always be voided a few minutes before the operation.

The frequency of the repetition of the injection must depend upon circumstances. In general, twice a day will suffice, but occasionally it is necessary to perform the operation three and even four times in the twenty-four hours; never, however, unless the fluid is very bland and unirritant. If it causes pain, smarting, or burning, beyond a few minutes, it should either be diluted, or used only once a day. From neglect of this precaution the disease is often aggravated, and the cure protracted. If the injection is found to disagree, or to prove unavailing, it should promptly be replaced by a more suitable one.

When the disease has reached its third stage, or has degenerated into *gleet*, it generally manifests a disposition to linger, or to remain stationary, with, perhaps, hardly any material variation in its character, for many weeks and even months together. It has, as it were, become inlaid in the mucous membrane, and usually proves extremely difficult to dislodge. It is a case alike annoying to the patient and the surgeon, who often finds his best skill and judgment at fault in selecting a suitable remedy. The best plan, in this condition, is for both parties to be patient. At all events, it is certain that the disease cannot be taken by storm. As it is chronic, so also must be the treatment. Very often success may be obtained by very mild and gentle means; perhaps, simply by attention to the diet and bowels, and by the use of some slightly astringent injection, as a grain each of acetate of lead and zinc, or the one-tenth of a grain of iodide of iron, to the ounce of water, aided by a few drops of balsam of copaiba several times in the twenty-four hours. If the patient is plethoric, he must be freely purged, and use antimonial and saline medicines, either alone, or along with a small dose of copaiba; the diet, too, must be very restricted, and stimulants of every kind must be interdicted. In a word, the treatment must be partly antiphlogistic, partly specific. If, on the other hand, the patient is feeble or anemic, tonics, as quinine and iron, must be given. The tincture of chloride of iron is also a useful article, and one that has almost acquired the title of a specific in the treatment of gleet, although it really possesses no such property. Its chief value appears to be due rather to its effects as a tonic than to any particular influence which it exerts upon the genito-urinary organs. It is often advanta-

geously combined, when there is no contra-indication on account of the state of the stomach, with copaiba, or cubebs; and I have repeatedly, especially when there was unusual atony of the urethra, given it with marked benefit in union with tincture of cantharides, the proper dose being about twenty-five drops of the former to ten, twelve, or fifteen of the latter, in a suitable quantity of water, every eight hours.

The diet, in these anemic cases, must also be more nutritious; and material benefit often occurs from the liberal allowance of ale, porter, or Holland gin, the latter of which, besides invigorating the digestive organs, generally produces a direct and specific impression upon the urinary apparatus. The patient should take gentle exercise in the open air, and use a cool or tepid shower-bath, followed by dry frictions, morning and evening. In short, no effort should be spared to improve the general health. Exercise on horseback is to be interdicted, as it tends to exert a pernicious influence upon the affected parts, and, for the same reason, sexual intercourse is to be scrupulously avoided.

The use of cubebs has been highly extolled in the treatment of this class of cases, on the ground of their alleged invigorating effects both upon the part and system. In my own practice, however, I have seldom realized such a result, and I, therefore, long ago ceased to place any confidence in them. If given at all, they should be employed in much larger quantities than in the subacute form of the disease.

Along with the remedies above mentioned, I am in the habit of employing as a local application, tincture of iodine diluted with four or five parts of alcohol, pencilled over the whole under surface of the penis, in the direction of the urethra, twice a day. Of all the topical measures that I have ever used in the treatment of this affection, I know of none that is so efficacious as this in dislodging the specific inflammation from the mucous follicles, where it frequently lingers long after it has left the main surface of the lining membrane. On one occasion, I effected a prompt cure of a gleet of nine month's standing, with a narrow blister stretched along the course of the urethra; the remedy, however, is very severe, and few patients will submit to its employment. Cantharidal collodion is a more elegant application than an ordinary epispastic.

When gleet proves very obstinate, resisting all the ordinary means, however judiciously or perseveringly employed, a speedy termination may often be put to its progress by the use of heroic injections, consisting of twenty to thirty grains of nitrate of silver to the ounce of water, and introduced into the urethra every twelve hours, until there is a free sanguinolent discharge with severe scalding in micturition. In some cases one such operation suffices to break up the specific disease, but most generally it is obliged to be repeated two or three times before the desired object is attained. However this may be, the treatment is to be followed by injections of some mucilaginous fluid, warm applications to the parts, rest, a full anodyne, and light diet; otherwise the new inflammation might readily extend to the bladder and testes. Instead of the nitrate of silver, I have occasionally used with excellent effect the tincture of iodine, in the proportion of twenty, twenty-five, or thirty drops to the ounce of water, employed in a similar manner.

I have said nothing, in these remarks, respecting the employment of medicated bougies in the treatment of gleet, so much vaunted by certain practitioners. I have the more willingly passed them by, because I am satisfied that their value has been greatly exaggerated, and that all the good they are capable of doing may readily be effected by the use of injections.

When the mucous membrane is thickly studded with granulations, the most effectual remedy is cauterization, conducted upon the same principle as in spermatorrhœa, or with a solution of nitrate of silver, from twenty to thirty grains to the ounce of water, applied by means of a rod armed with a sponge or wadding passed through a straight catheter open at the vesical extremity. The operation, in either case, should be performed with great care, and should not be repeated oftener than every fourth or fifth day.

Finally, whatever measures be adopted for the relief of gonorrhœa, considered in reference to all its stages and grades of character, it is a matter of the first moment, in regard to the permanent cure of this disease, that the treatment should be continued, uninterruptedly, for at least six or eight days after all discharge has apparently ceased. When this precaution is neglected, there is always great danger of a speedy return of the disorder, thus compelling both patient and practitioner to go through a similar routine.

The treatment of the *local complications* of gonorrhœa must be conducted upon general antiphlogistic principles, modified by the peculiar character of each affection. With the exception of chancre, they are to be viewed, not as independent lesions, but as maladies owing their existence entirely to gonorrhœa, or to the specific inflammation of the mucous membrane, of which, in fact, most of them are merely a continuation.

The *chordee*, which is often such a very troublesome symptom, usually disappears with the inflammation which causes it; hence, antiphlogistics are always the most suitable remedies for combating it radically. Immediate or temporary relief is best secured by antispasmodics, especially morphia and tartarized antimony, half a grain of the former with one-sixth of a grain of the latter being given towards bedtime. Under the influence of this prescription the patient soon falls asleep, copious diaphoresis ensues, and a tranquil night is passed. The same object may generally be readily attained by an opiate suppository, or by an enema of a drachm of laudanum, or of this quantity of laudanum and twenty grains of camphor, dissolved in alcohol, and mixed with some mucilaginous fluid. If the parts are hot and violently excited, they should be covered with cloths wrung out of cold water, and frequently renewed. Cold water douches to the penis generally afford prompt temporary relief.

The *induration* of the spongy structure of the urethra, caused by inflammatory new formations, gradually disappears under the steady use of mercurial inunctions and sorbefacient lotions, aided by the exhibition of an occasional dose of blue mass, or a minute quantity, thrice a day, of bichloride of mercury.

Cystitis usually readily yields to leeches to the perineum, the warm hip-bath, hot fomentations to the hypogastrium and genitals, and full anodynes with tartarized antimony, to allay spasm of the organ and promote relaxation of the system. In plethoric subjects the lancet may be required. If retention of urine take place, and antispasmodics fail to afford relief, the catheter must be used.

Phlebitis of the penis requires saturnine and anodyne lotions, conjoined with rest and elevation of the parts. If the inflammation is severe, a brisk purgative and leeching may be necessary.

If *epididymitis* be present, the lancet, or, at all events, leeches will be demanded; the bowels are opened with a brisk cathartic, and free use is made of saline and antimonial medicines, in slightly nauseating doses. Light diet and perfect rest are enjoined; and the affected organs, carefully suspended, are kept constantly wet with a solution of acetate of lead and tincture of opium, applied either warm or cold, as may be most agreeable to the part and system. No attempt is made by direct medication to reinvoke suppressed discharge; as the inflammation subsides this will be sure to return of its own accord, without risk of bad consequences. Slight ptyalism may be necessary to rid the glandular structure of induration and swelling; and a careful supervision must for a long time be exercised over the general health.

Bubo is treated antiphlogistically; by rest in the recumbent posture, active purgation and light diet, and by the application of iodine and emollient cataplasms, medicated with acetate of lead, and tincture of opium.

The *hemorrhage* which occasionally attends this disease is seldom so copious as to require special interference; when it does, it will generally be found to yield very promptly to applications of pounded ice in a bladder, aided by compression with the catheter. Internally acetate of lead, ergot, and morphia may be used.

The coexistence of *chancre* with gonorrhœa always constitutes a serious complication, tending to perpetuate the inflammation, and to endanger the constitution by the absorption of the syphilitic poison. The principal local remedies are, the application of dilute tincture of iodine, over the site of the chancre, the use of emollient poultices, and frequent injections, at first of tepid water, and afterwards of tannic acid and red wine, yellow wash, or a weak solution of nitrate of silver. If the chancre is hard, or difficult to heal, a mild course of mercury may be required; and it is astonishing how rapidly, under this treatment, the disease usually subsides. All harsh and irritating remedies are, of course, out of the question.

Abscesses, forming along the course of the urethra or perineum, are treated in the same manner as abscesses in other parts of the body; antiphlogistically in the first instance, and by free incision afterwards, sufficiently early to anticipate serious destruction of tissue and the occurrence of urinary fistule.

For the cure of *balanitis* very simple treatment is generally sufficient. The patient is purged with some cooling medicine, and kept at rest on a restricted diet, while

the parts are frequently bathed with cold or tepid water, and covered, in the interval, with an emollient poultice, or medicated dressings. If the foreskin is too narrow, or too much swollen, to admit of retraction, the use of the syringe will be necessary, simple water, or some gently astringent lotion, as a solution of acetate of lead, or Goulard's extract, being frequently thrown into the preputial bag, both to promote cleanliness and to stay inflammation. Harsh and irritating applications are carefully abstained from. In many cases prompt improvement follows the injection of a solution of tannic acid and opium in water and red wine. In the chronic form of the disease the use of a very dilute ointment of nitrate of mercury often rapidly conduces to a cure. Keeping the inflamed surfaces in a state of isolation by the interposition of a piece of soft lint always exerts a salutary influence, and greatly expedites recovery.

If symptoms of *rheumatism* arise, the ordinary antiphlogistic means must be used, along with Dover's powder, opium, and calomel, or morphia and colchicum at night. When the disease has reached the subacute stage, recourse must be had to iodide of potassium, in union with bichloride of mercury, especially if there is evidence of deposits of plastic matter. Tonics and change of air will be necessary when the malady is rebellious. Topically the usual remedies must be employed, as saturnine and anodyne lotions, leeches, iodine, and blisters, the latter being particularly valuable in cases of copious synovial secretions. No benefit will be likely to accrue from the exhibition of copaiba and cubebs.

The treatment of gonorrhœal *ophthalmia* is discussed at sufficient length in the chapter on the Diseases of the Eye. The conjunctival form of the affection generally proves destructive, despite the best directed efforts of the surgeon. For the sclerotic variety, the most efficient remedies are bloodletting, local and general, calomel and opium, sudorifics, blisters to the nape of the neck, and the application of atropia to the eyebrows, forehead, and temples.

The treatment of *pyemia* must be conducted upon ordinary principles. The secretions must be promptly corrected, the condition of the blood improved, and the vital powers sustained.

SECT. VIII.—NON-SPECIFIC URETHRITIS.

The male urethra is sometimes the seat of a non-specific discharge, so closely simulating that of gonorrhœa as to render it very difficult, if not impossible, to distinguish between them, especially when it occurs in married men. It has been supposed that such a disease might be contracted during intercourse with women laboring under leucorrhœa, and other ordinary utero-vaginal affections, and this is probably the fact, the occurrence being the more likely to happen when there exists an unusual proclivity in the urethra to inflammation. A muco-purulent discharge of this canal is occasionally met with in young men, independently of sexual intercourse. I am acquainted with a highly intelligent physician who seldom fails to suffer in this way whenever he labors under dyspepsia or an attack of hemorrhoids; to both of which he is rather subject. On several occasions the discharge has been coincident with an attack of rheumatism. Children are sometimes affected in a similar manner. In May, 1859, Dr. Bournonville sent to me a male infant, seven months old, from whose urethra there had been more or less of a muco-purulent discharge for upwards of a month. The child had become affected, soon after its birth, with eczema, but this had long ago disappeared, and at the time I saw him he was very stout and robust. I recollect a boy, between three and four years of age, in whom the disease existed in a marked degree for a number of weeks, and still another, nearly ten years old, in whom the discharge could not have been more thick and profuse, if he had labored under genuine gonorrhœa. Such attacks have their analogy in the vaginal profluvia of little girls.

Simple urethritis is most commonly met with in unhealthy, delicate children, predisposed to cutaneous disease and disorder of the digestive apparatus. Occasionally, it can be traced to the irritation of worms in the alimentary canal, to stone in the bladder, or organic lesion of the anus and rectum, as ulceration and hemorrhoids.

However induced, the symptoms do not differ essentially from those of gonorrhœa. The disease is generally ushered in by a peculiar itching, or stinging sensation, rapidly followed by heat in the part, unnatural redness of the meatus, and slight scalding in passing water. The discharge is at first thin and gleet, like the white of egg, but

it soon becomes muco-purulent, thick, yellowish, and very abundant. When it supervenes upon sexual intercourse, it generally sets in within the first twenty-four hours.

The most reliable diagnostic circumstances are, the history of the case, the age of the patient, the suddenness of the attack, the comparative smallness of the discharge, and the facility with which the disease yields to treatment. When such an affection occurs in a married man, or in a man accused of rape, the surgeon cannot be too cautious in the expression of his opinion respecting its true character.

In some cases the disease is very obstinate; in others, it either soon disappears of its own accord, or yields to very mild remedies. Diligent inquiry should always be made into the nature of the exciting cause. The general health must be amended, cooling laxatives must be given, and the utmost attention must be paid to cleanliness. If these means do not speedily effect a cure, copaiba and astringent injections must be employed in the same manner as in true gonorrhœa. When tonics are required, the best articles are iron and quinine with *nux vomica*. Should the discharge be connected with a rheumatic state of the system, the exhibition of *colchicum* will be beneficial.

SECT. IX.—SPERMATORRHŒA.

A loss of semen is one of the natural consequences of manhood; it is a necessity of the system, and is, therefore, to be regarded as a disease only when it occurs too frequently, or when it is provoked by improper means. When this is the case, it may be followed by the most deplorable results, both bodily and mental.

The great cause of this disorder is masturbation, but it may also be produced by excessive venery, gonorrhœa, stricture of the urethra, contraction and elongation of the prepuce, stone in the bladder, hemorrhoids, fissure of the anus, *ascarides* in the rectum, and disease of the cerebellum and spinal cord. *Spermatorrhœa* is frequently attendant upon locomotor ataxia, especially in its earlier stages, at first with and afterwards without erection of the penis. The irritation on which it more directly depends is seated at the neck of the bladder, the ejaculatory ducts, and the seminal vesicles, the mucous membrane of which is in a state of morbid sensibility similar to that occasionally witnessed in the eye, nose, fauces, and larynx. Masturbation is a common vice among youth, and, once established, is liable to be followed by the most serious consequences, both as it respects the health and the happiness of the individual. At first, the emissions are strictly voluntary; they take place under the influence of a lascivious dream, or an excited state of the brain, and are attended by the usual feeling. By and by, however, as the local irritation increases, they occur without sensation, and even without consciousness, either during sleep, or while the patient is at the water-closet. When the habit is fully established, there may be five or six discharges a week, or even as many as two or three in the twenty-four hours. The disease may continue in this state for years, without any decided abatement. The seminal fluid itself, although secreted in preternatural quantity, is without ropiness, very thin, and characterized by a strong odor.

It is hardly to be expected that an affection which keeps up such a constant drain upon the system should continue long without seriously disturbing the general health. Among the earlier symptoms denotive of this circumstance are, derangement of the digestive organs, attended with constipation of the bowels, occasional headache, and nervous tremors. At a more advanced period, the patient is harassed with palpitation and dizziness, his sleep is disturbed at night, his extremities are cold, his body exhales a peculiar seminal odor, he shuns society, and is a prey to gloom and despondency. The erections are imperfect, the testes waste, and there is a feeling of numbness and coldness in the thighs, scrotum, and perineum. Impotence, more or less complete, is one of the most common effects of this disorder in protracted cases. When the disease is fully established, the patient labors under loss of memory, his actions are those of a poltroon, he is incapacitated for business, and he is unable to look any one in the face. In a word, he is mentally and physically emasculated. Epilepsy and insanity are occasional consequences of this vile practice. In the report of the Longview Asylum for 1863, masturbation is assigned in nearly one-sixteenth of the cases as the cause of the mental disorder; and the statistics of some of our other insane institutions exhibit an equally frightful proportion.

The diagnosis of *spermatorrhœa* is generally very easy. The only affection, in fact, for which it is liable to be mistaken is *prostatorrhœa*, a discharge of mucus from

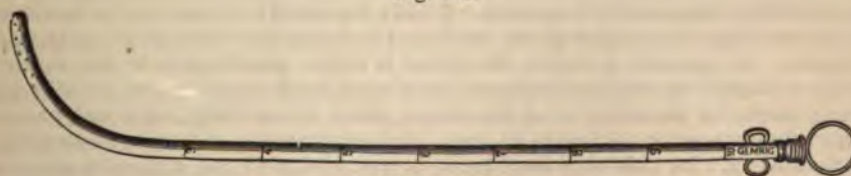
the urethra and prostate gland, especially when it occurs at the water-closet from severe straining in defecation, or during strong sexual excitement. Under such circumstances, it is not uncommon for a few spermatozoa to be mixed with the mucus, but the number is too small to constitute the disease. Nor must the occasional presence of spermatozoa in the urine be looked upon as, in itself, an evidence of seminal disorder, inasmuch as bodies of this kind are not unfrequently seen in this fluid in young and middle-aged persons in perfect health.

The *treatment* should be commenced as early as possible; for the longer it is deferred the more danger will there be of permanent impotence and wretchedness. The milder cases, after riddance of the exciting cause, often recover spontaneously, or under the use of very mild means, as a proper regulation of the diet and bowels, exercise in the open air, cold bathing, and sleeping upon a hard mattress. Circumcision will be necessary when there is hyperæsthesia of the head of the penis from the irritation of retained sebaceous matter consequent upon elongation and contraction of the prepuce. When the parts are morbidly sensitive, leeches may be applied to the perineum, and use made, twice daily, of some astringent and anodyne injection, as a solution of acetate of lead and opium, in the proportion of three grains of each to the ounce of water. But a very different mode of management will be required when the disease is fully established, especially when it is dependent upon habitual onanism. The best local treatment, then, at least in many cases, is cauterization, but before resorting to this expedient, the urethra should be well explored with a bougie, or silver catheter, to ascertain the precise seat of the irritation. This will sometimes be found in front of the membranous portion of the urethra, but, generally, it is farther back, at the neck of the bladder, or, more correctly speaking, at the orifices of the ejaculatory ducts and the anterior extremity of the gallinaginous crest, where it is often so great that the patient will shrink from the mere contact of the instrument. Occasionally the morbid sensibility is diffused over the whole surface of the urethra, from one end to the other, and then the passage of the bougie is liable to be followed by excessive pain and even syncope. The seat of the irritation having been ascertained, the caustic—a bit of nitrate of silver, inserted in the instrument sketched at page 821—is conveyed down to the requisite distance, and held there from five to ten seconds, when it is cautiously withdrawn, as the object is merely an antiphlogistic one. Carried beyond this, the remedy becomes a cause of abuse, likely to be followed by harm instead of benefit.

If any inconvenience be experienced after the operation, a little morphia may be given, or, what I usually prefer, two drachms of paregoric. The cauterization is repeated once a week until the morbid sensibility of the part is entirely destroyed. It is seldom that more than three or four applications will be required.

Instead of the solid nitrate of silver, a solution of this salt may often be advantageously employed, in the proportion of ten to twenty grains to the ounce of water. The fluid is conveyed directly to the prostatic portion of the urethra by means of a syringe such as that represented in fig. 644, shaped like an ordinary catheter, and

Fig. 644.



Syringe Catheter.

perforated with numerous openings at the distal extremity. The injection should not be repeated oftener than once in six, eight, or ten days.

Cold bathing, general and local, is often highly beneficial. Dashing cold water against the perineum, scrotum, penis, and inside of the thighs is useful. Some persons, especially such as are of a nervous, irritable temperament, experience greater advantage from warm bathing than from cold. Occasionally marked relief arises from cold enemas, repeated twice in the twenty-four hours. When the patient is plethoric, as is sometimes the case in the early stage of the disease, leeches may

be applied to the perineum, followed, if the local excitement is unusually great, by a blister, a small seton, or an issue. When the morbid sensibility of the urethra is very extensive, obstinate, or persistent, the treatment should be aided by the injection, twice a day, of a weak solution of nitrate of silver and opium in the proportions of about two grains of the former and five of the latter to the ounce of water. Sulphate of zinc, Goulard's extract, and acetate of lead, also answer extremely well in cases of this kind. The injection should be forced as far back as possible, and be retained two or three minutes in the canal, in order to afford thorough medication. In some cases the irritability of the urethra promptly yields to the daily use of a full sized bougie retained for half an hour at a time. The morbid erections so often present in spermatorrhea are generally easily controlled by anodyne enemas, or by opium, belladonna, and tartar emetic given by the mouth at bedtime.

A total abandonment of masturbation, and temporary abstinence from sexual intercourse, are indispensable to a cure. The patient must sleep upon a hard mattress, and everything stimulating, whether in the form of food, drink, or medicine, must be carefully avoided. The bowels must be kept soluble by mild aperients. Exercise in the open air is an important auxiliary. Riding on horseback is injurious, as it has a tendency to create undue excitement in the genital apparatus. Sometimes an entire change of occupation affords more relief than anything else.

When the patient, despite his utmost determination, finds it impossible to resist his bad habit, the whole skin of the penis should be frequently painted with dilute tincture of iodine; or, this failing, vesicated with cantharidal collodion.

When there is great prostration of the system, with restlessness and loss of sleep, the use of tonics, as quinine and tincture of iron, with hyoscyamus or opium, is indicated. Dilute phosphoric acid sometimes exerts a powerful restorative influence. In such cases a change of air, and the daily use of the shower-bath, greatly promote recovery. The diet should be light, but nutritious, and a glass of generous wine should be allowed at dinner. Should there be reason to believe that the emissions are dependent upon cerebellar irritation, the chief reliance must be upon leeches and blisters to the nape of the neck, cold shower-baths, and other soothing measures. Much has lately been written in favor of lupulin, as a sedative, in this disease; but, although I have frequently employed it, it has never done any good in my hands. When such a remedy is required, the best article that I know of is bromide of potassium, given three times a day, in doses varying from twenty to thirty grains, in union with five drops of tincture of aconite, in half an ounce of camphor water. I have also used with excellent effect, in a number of cases, bromide of ammonium in conjunction with tincture of cypripedium. The action of these medicines is powerfully sedative, and they are worthy of much greater attention than has hitherto been accorded to them in this particular class of affections.

When, by the above measures, the system has regained its natural tone, and the sexual apparatus its accustomed vigor, the best guarantee against relapse is marriage. Upon this point, however, it is impossible to be too cautious.

The practice of onanism often engenders a want of confidence in young men, in regard to their ability to consummate the marriage contract. In fact, it renders them sometimes temporarily impotent. I have repeatedly known this to be the case after the marriage had taken place, much to the annoyance both of the patient and the surgeon. In general, however, the defect is rather mental than bodily, and may easily be corrected by entire abstinence for several weeks, and by the use of a little medicine, such, for instance, as a few drops, three times daily, of equal parts of tincture of nux vomica, chloride of iron, and cantharides, with the assurance of speedy recovery. In this way confidence is restored, and the difficulty soon vanishes. Occasionally the obstacle is caused by too great eagerness on the part of the individual, or by too frequent indulgence soon after marriage. At other times, again, the erections are imperfect, or the act is prevented by a premature emission. These effects frequently subside of their own accord; when they do not, an attempt should be made to correct them by a judicious course of treatment, especially by the use of tonics, the shower-bath, galvanism, and attention to the bowels and secretions, conjoined, if the parts are morbidly sensitive, with cauterization of the urethra, and mildly astringent injections.

SECT. X.—SATYRIASIS.

Satyriasis is a term employed to designate that peculiar condition of the brain and genital organs, characterized by incessant erections, an ungovernable desire for sexual indulgence, and an erotic state of the mind bordering upon delirium. It is, in fact, a species of insanity, essentially similar to nymphomania. Fortunately the desire, so revolting in its nature, and generally so deplorable in its consequences, is exceedingly uncommon, otherwise society might find it difficult to protect itself against the assaults of its subjects.

Men of the most virtuous habits are not exempt from attacks of this kind. Priests and penitents who, in obedience to their vows, have all their lives scrupulously abstained from sexual intercourse, and practised, in all respects, the most perfect self-denial, have been known to suffer most frightfully from satyriasis, despite their best directed efforts to prevent and counteract it. In general, however, the subjects of satyriasis are men of dissolute habits, debauchees, and onanists, who in early youth abandoned themselves to practices of the grossest immorality.

The causes of this complaint reside either in the brain, or brain and spinal cord, in the genito-urinary apparatus, or in a defective state of the general health. The disease may also be provoked by the inordinate use of cantharides, administered for medicinal purposes, or designedly to excite the sexual appetite. However induced, the mind is speedily involved in the venereal affection.

The worst forms of satyriasis nearly always depend upon some disorder or other of the cerebellum. The intimate connection between this organ and the genital apparatus, demonstrated long ago by Gall and Spurzheim, has been placed in a very satisfactory light by clinical observation. Numerous instances of injury have occurred tending to show that, when the cerebellum is seriously affected, the patient is often seized with the most desperate priapism, attended with an erotic state of the mind, and such a degree of salacity as to render it unsafe for any female, even a member of his own family, to be in the same apartment with him. Sometimes the effects are primary, coming on almost immediately after the receipt of the injury; at other times secondary, or more or less remote. Mere concussion of the cerebellum, from a blow on the occiput, or the upper and back part of the neck, is occasionally sufficient to provoke the disease. Mr. Robert Dunn, of England, has recorded a case in which satyriasis supervened upon an attack of apoplexy. The patient was a man, fifty-two years of age, who, along with many other singular vagaries, was afflicted with an almost uncontrollable desire for coition. After death a considerable portion of the right hemisphere of the cerebellum was found to be converted into a softened, pulpy mass, in the midst of which there was a clot of blood, of the size of a pullet's egg. There are facts upon record which go to prove that mere congestion of the lesser brain, especially if at all severe, is capable of producing satyriasis.

Satyriasis, dependent upon irritation, disease, or injury of the genito-urinary apparatus, is of constant occurrence, and does not require any special comments. Chancre of the penis, want of cleanliness of the prepuce, inflammation of the urethra, and irritation of the bladder, prostate gland, and seminal vesicles may be enumerated as so many causes of the complaint. It is seldom, however, that satyriasis thus induced is either so severe or obstinate as when it arises from injury or disease of the brain.

Men and even boys in ill health are often troubled with morbid erections and an almost irresistible desire for connection, accompanied with frequent nocturnal pollutions. A similar effect is often experienced during the progress of serious, protracted, and exhausting maladies. Many years ago I attended, along with Dr. Knight and Dr. Rogers, of Louisville, a young physician, who was slowly but, as we had reason to believe, safely convalescing from a severe attack of typhoid fever. Despite our remonstrance he indulged his passion, immediately grew worse, and died within a few days completely exhausted. Priapism and intense venereal desire are occasional symptoms of acute peritonitis.

The abuse of aphrodisiacs is capable of exciting satyriasis. This is especially true of cantharides, occasionally resorted to by the jaded and worn-out debauchee to provoke erections and to prolong the gratification of his passions. The absorption of the active principle of cantharides stimulates the seminal vesicles and by reflex action irritates the cerebellum.

When the disease is fully established, there is complete perversion of the intel-

lectual and moral faculties. The sleep is disturbed by the wildest dreams, and the imagination is a prey to the most lascivious images. Sexual indulgence, instead of calming the feelings, only serves to augment the suffering. The erections are constant; the seminal emissions frequent. Fever is not always present, but there is generally great disorder of the digestive apparatus, with constipation of the bowels, a fiery expression of the eye, scintillations, buzzing of the ears, and an exhalation of a peculiarly offensive odor from the skin. If relief is not afforded, the patient, in the more severe cases, falls into a state of delirium, followed by convulsions, paralysis, and death. In the milder forms, the morbid excitement gradually wears off, and restoration eventually occurs.

In regard to the *treatment* of this complaint no definite rules can be laid down. When it depends upon organic disease of the cerebellum, or of the brain and spinal cord, the merest palliation alone is to be hoped for. The most reliable means are leeches and blisters to the occipito-cervical region, tartar emetic and opium in full and frequent doses, efficient purgatives, anodyne enemata, shower-baths, cold lotions, a restricted, unirritant diet, and gentle exercise in the open air. Bromide of potassium, in doses of thirty to sixty grains three times a day along with a moderate quantity of belladonna, is worthy of trial in the more simple forms of the disease, from its well-known soothing influence both upon the nervous system and the genito-urinary apparatus. The patient should exclude himself from female society, and avoid everything calculated to excite his imagination. The violence of the paroxysm might be controlled by chloroform. In very obstinate cases, cauterization of the prostatic portion of the urethra should be employed. Castration, proposed by some of the older surgeons for the cure of this disease, is a cruel and useless remedy.

SECT. XI.—IMPOTENCE.

Impotence is not only of frequent occurrence, but, from the depressing influence which it invariably exercises both upon the mind and body, is worthy of the most serious consideration. Indeed, I know of no class of cases more likely to interest the feelings and sympathies of a conscientious practitioner. The term "impotence," as I understand it, simply implies inability to copulate, in contradistinction to the term "sterility," which signifies incapacity to procreate. An individual may be unable to propagate, and yet possess the faculty of sexual intercourse.

The causes of impotence are of two kinds, physical or mental, real or imaginary, permanent or temporary. The first relate to various defective states of the body, more especially of the genito-urinary apparatus; the second, to the condition of the mind, or of the brain and its dependencies. Under the former head may be arranged impotence, 1st, from imperfections of the penis; 2dly, from absence, atrophy, and other defects of the testicles; 3dly, from disease of the bladder, urethra, and prostate gland; and, 4thly, from disorders of the seminal vesicles and their excretory ducts.

1st. Absence of the *penis*, whether congenital or accidental, is, of course, an absolute cause of impotence. Excessive brevity is also a disqualifying circumstance. Persons affected with exstrophy of the bladder are unable to copulate, from the defective condition of the penis. Extreme length might serve as an obstacle, but would only be a relative cause of impotence. Excessive volume, as that arising from elephantiasis, arterio-venous formations, and other morbid growths, may effectually interfere with the intromission of the organ. Carcinoma and syphilitic warts, present in a high degree, also act obstructingly. Wounds of the penis, tearing away portions of the cavernous bodies, occasion impotence by preventing erections. The permanent retention of a ball in the penis, as in a case previously referred to, might produce a similar effect. The presence, however, of a foreign substance in this organ does not necessarily interfere either with copulation or procreation. A case has been recorded by Liston in which a man performed with ability all his sexual functions, and ultimately became the father of a family, notwithstanding a brass curtain-ring, used to prevent incontinence of urine, had been buried in his penis ever since he was eight years of age. Late in life, however, after the ring had become incrustated with calculous matter, the organ was very unserviceable, and an operation was necessary for his relief. Authors refer to a bifid state of the penis, as a cause of impotence, but such a formation must be extremely uncommon.

Inordinate bulk of the penis, rendering the organ utterly unfit for copulation, as

well as procreation, may arise from the presence of a calculus in the urethra. Sabatier refers to a case where such a body weighed three ounces, and Duméril saw one in which it was nearly three times as heavy. An instance is reported in a previous part of this work in which the prepuce of a man, converted into a large pouch, contained upwards of one hundred concretions. Sper, of Toulon, attended a patient who for thirty years was debarred from sexual intercourse by the presence of calculus in the foreskin. Excessive enlargement of the prepuce, from inflammatory deposits, may effectually interfere with copulation.

Impotence, of a permanent character, may be caused by extravasation of blood into the cavernous bodies of the penis, as in the interesting case observed by Mr. Callaway, of London. A man, in a state of inebriation, after having had connection with his wife three times in the same night, suffered from persistent priapism for sixteen days, notwithstanding the employment of appropriate remedies. An incision was now made into the penis, below the scrotum, and a large quantity of grumous blood, with a number of small coagula, pressed out, with the effect of the immediate return of the flaccidity of the organ. After recovery, however, he continued to be perfectly impotent, from inability to command erections, owing, as was supposed, to the distention and agglutination of the cells of the cavernous bodies with inflammatory new formations. A similar effect is sometimes produced in chordee, consequent upon gonorrhœa and external injury.

A vicious direction of the penis may effectually oppose copulation. The most common form is that in which the organ is inclined, more or less strongly, towards the perineum, from a defective condition of the urethra, as in hypospadias. The deformity is usually associated with remarkable brevity of the penis, thus seriously aggravating the difficulty. McClellan met with a case, in a man between fifty and sixty years of age, in which the curvature was caused by a cartilaginous and osseous degeneration of the pectiniform septum. The organ was almost entirely unserviceable, until relieved by operation. Lateral deviation is sometimes occasioned by a similar condition of the fibrous sheath of the cavernous bodies. I have seen a considerable number of cases, chiefly in elderly subjects, of imperfect erections growing out of the existence of numerous patch-like pieces of cartilage in these structures. Great incurvation of the penis, interfering with intromission, has been known to be caused by a very short frenum.

Finally, impotence may depend upon excessive enlargement of the scrotum, as in hydrocele, elephantiasis, and hernia, dragging the penis out of place, or even completely concealing it within the morbid growth. I recollect the case of a stout, corpulent man, sixty-three years of age, who was tried for rape and bastardy, but was acquitted, because the entire penis, excepting a little of the head, was buried in an enormous, irreducible rupture, nearly twelve inches in length by twenty inches in circumference. Intromission in such a condition could hardly be possible.

2dly. Impotence often depends upon defective states of the *testicle*. These organs may be entirely absent, as a congenital vice, or they may be removed by accident, by self-castration, or by operations performed on account of disease. Sometimes they are unusually small—perhaps not larger than a small bean—and at the same time very soft and spongy. I have met with several such cases, and in all the defect was congenital and implicated both organs.

Atrophy, properly so called, of this organ may arise from various causes, of which injury of the posterior part of the head is, perhaps, the most common. The intimate connection which naturally exists between the testes and the cerebellum is well known, and it is, therefore, easy to perceive how violence inflicted upon the latter through the back part of the skull should exert a prejudicial influence upon the former. The wasting thus induced is generally very gradual, although not unfrequently it proceeds until there is complete destruction of the tubular texture. Since Larrey first called attention to the subject, numerous cases of it have been reported by different observers, in most of which the atrophy was complete. The influence of the brain upon the development of the testes is well illustrated in idiots and cretins, in whom these structures are often remarkably diminutive, in consonance, apparently, with the imperfect condition of the cerebellum.

Another cause of atrophy of the testicle, by no means uncommon, is inflammation. Mr. Curling, indeed, thinks that it is the most frequent of all. The disturbance created in the functions of the organ by the new formation often continues after the morbid action has lost its acute character, until the merest vestige of the organ

is left. Parotitis was formerly supposed to be a prolific cause of atrophy of the testicle, but experience has shown this opinion to be unfounded, although now and then a case, as I have myself seen, is met with. It rarely affects both organs, and then seldom in the same degree.

Among the more uncommon causes of atrophy of the testicle are, the inordinate use of tobacco, neuralgia, paraplegia, onanism, excessive venery, and the compression occasioned in hydrocele, varicocele, hematocele, elephantiasis, and scrotal hernia. A case has been related by Mr. Wardrop, in which both organs were completely wasted in consequence of the obliteration of the spermatic arteries by the compression of an aneurism of the aorta. The immediate cause of the atrophy in these and similar affections is defective nutrition from the want of blood and nervous fluid.

A considerable number of cases of complete destruction of the testicle from the effects of tertiary syphilis have fallen under my observation. When the disease involves both organs, irremediable impotence is likely to occur, from the annihilation of the tubular structure.

Both testes may be retained in the abdomen, or one may remain there and the other descend into the scrotum. In neither case will the person necessarily be impotent. Atrophy, more or less complete, may seize upon these organs when they are retained in the inguinal canal, from the severity of the pressure of the abdominal muscles.

Curling describes the case of a married man, who, in consequence of severe neuralgia of one of his testicles, was unable to cohabit with his wife, from the excessive pain he suffered before and at the time. It was so violent as almost to cause syncope.

A defective condition of the testicle, if congenital or produced prior to the age of puberty, is invariably characterized by an effeminate state of the voice, by the absence of beard and hair upon the pubes, by an imperfect development of the penis, and by all the other features, physical and moral, of eunuchism.

3dly. Impotence from disease of the *bladder*, *urethra*, and *prostate gland* is infrequent, although, perhaps, less so than is generally imagined. Chronic inflammation, calculous affections, and paralysis of the bladder always seriously impair, and often completely destroy, the aptency for sexual intercourse. The erections, if any, are transient and imperfect. Excessive hypertrophy of the prostate gland is followed by similar results. In stone of the bladder, projecting forwards into the prostatic portion of the urethra, the gland is sometimes completely excavated, or converted into a large cyst, attended with the destruction of the ejaculatory ducts, and the corresponding portion of the urethra. Occasionally this body is completely effaced by calculi originally formed in its own substance. Men affected with tight, callous strictures are seldom capable of commanding full, healthy erections. Allusion has already been made to the enervating effects exerted by the presence of earthy concretions in the urethra upon the penis, considered as an organ of copulation.

4thly. There is no doubt that certain diseased conditions of the *seminal vesicles* may occasion impotence, or an incapacity to copulate; but we are hardly sufficiently acquainted with these conditions to enable us to speak of them with any degree of certainty. These organs are, as is well known, liable to inflammation, abscess, tubercular deposits, the fibroid degeneration, and the development of earthy concretions, completely undermining structure and function, and proportionately weakening, if not thoroughly annihilating, sexual power. The baneful effects of onanism, spermatorrhœa, and of all kinds of venereal excesses have already been described.

Cerebral impotence may depend solely upon the condition of the mind, or upon various morbid states of the brain, spinal cord, and nerves. Various bodily states, not directly connected with the nervous system, may also give rise to it.

The intimate connection between the mind and the genital organs is well known. A disagreeable idea, a suspicion of chastity, or any unpleasant emotion, no matter of what character, will often instantaneously arrest the most voluptuous enjoyment, and render any further effort fruitless. The young husband, in his eagerness to consummate matrimony, not unfrequently finds himself completely baffled in his expectations. A want of confidence is a pregnant source of disappointment, sometimes for weeks, or even months, and is, perhaps, at last surmounted only by the favorable impression made by our remedies upon the patient's mind. In an instance

under my own care, everything had signally failed for nearly half a year, until I recommended the use of a strong infusion of hypericum, with the assurance that it had often acted like magic in such complaints. Complete relief speedily followed, not from any specific effect of the medicine, but from the confidence inspired in its infallibility. The advice of Hunter to a gentleman who had lost his virility has frequently been quoted. The inability was wholly mental, and completely vanished after a resolute abstinence for six nights.

Impotence is sometimes relative, that is, a man may be able to cohabit with one woman but not with another, owing, apparently, to disgust or aversion. The famous case of the Earl of Essex, in the reign of James I., is a memorable example of this nature. A man has occasionally been unable to consummate the act upon finding that the woman was not a virgin, and conversely.

"An attack of apoplexy," says Curling, "often permanently extinguishes all desire as well as capacity for coition." Paraplegia weakens, but does not necessarily destroy, sexual power. Habitual inebriates are generally indifferent to the pleasures of Venus, and may even be entirely deprived of the faculty of erection. Hard study greatly diminishes the desire for copulation. The effects of injury upon the posterior part of the head in impairing virility have already been mentioned. Protracted and wasting maladies, as typhoid fever, albuminuria, diabetes, dropsy, dyspepsia, cardiac affections, aneurism of the aorta, pulmonary phthisis, and psoas abscess are among the recognized causes of impotence. Dr. Begbie has shown that the oxalic diathesis diminishes the sexual power, and occasionally entirely extinguishes it. The phosphatic diathesis acts similarly, but in a less degree. Nitrate of potassa, carbonate of soda, and various other diuretics possess anaphrodisiac properties.

SECT. XII.—STERILITY.

Sterility, infecundity, or inability to procreate depends essentially upon three causes: 1st, a defective condition of the spermatozoa; 2dly, inability to bring the seminal fluid in contact with the genital organs of the female; and, 3dly, a want of congeniality in the two sexes.

1st. The semen is a vital fluid, and, therefore, like the blood from which it is derived, susceptible of important alterations. Its fecundating properties are directly due to the presence of innumerable little corpuscles, known as zoosperms or spermatozoa. Of a soft consistence, and of perfectly homogeneous appearance, they are of a peculiar filiform shape, with a large, flattened pyriform head. The body and tail are exceedingly slender, and terminate in flat, tapering points, hardly distinguishable even with a powerful magnifying glass. The zoosperms are naturally very active, capable of rapid and varied movements, and remarkably tenacious of life, retaining their power of motion often for hours after they have been expelled. They are developed in the testes, but acquire their greatest perfection in the deferent tubes and seminal vesicles. They are suspended in what is called the seminal liquor, a viscid, colorless fluid, very small in quantity, and intermixed with the secretions of the seminal vesicles and prostate gland, which always constitute the greatest bulk of an emission. The peculiar odor of this fluid is altogether adventitious, and has no connection whatever with the fructifying influence of the semen. Spermatozoa may often be detected after emissions in which the generative fluid comes in contact with the person's linen, even after the spots have been dried, provided they be remoistened with distilled water.

It is probable that no zoosperms are formed until the age of fourteen to sixteen years, and, therefore, up to this period the power of procreation does not exist, although the testicles secrete more or less fluid. The age at which they cease to be produced is undetermined. It is not uncommon for men of seventy, seventy-five, and even eighty to possess the faculty of procreation, as is clearly evinced by the resemblance of their offspring. The memorable example of Parr, at a far later period of life, is well known. Duplay found zoosperms in thirty-seven out of fifty-one men between sixty and eighty-six years of age who died of various acute and chronic diseases. In the other fourteen no traces of any existed. In twenty-seven of the cases, the zoosperms were perfectly normal, and similar in every respect to those of the adult. In the other ten cases, on the contrary, they had lost their tails, and were more or less deformed in the head.

Aspermatism, that is, complete absence of seminal liquor, always exists in persons in whom the testes are wanting or more or less defective, either congenitally or accidentally, as the result of operations, external injury, or wasting disease, attended with disturbance of nutrition. Zoosperms are rarely entirely absent in ordinary maladies. In organic affections of the testicles, as cystic degeneration, encephaloid, and tertiary syphilis, they always gradually disappear with the morbid deposits, although, as only one organ is generally involved, the individual is not necessarily impotent.

Chronic double epididymitis, the result of gonorrhœa, is often a cause of sterility, especially when it is followed by callosity of the organ. Of twenty cases of this disease, examined by Gosselin, no spermatozoa could be detected in fifteen, although the seminal fluid appeared to be normal and the sexual powers were not impaired. The other cases were of longer duration, and in all, except one, there was an absence of zoosperms.

Masturbation and venereal excesses may effectually prevent the formation of spermatozoa, by depriving the testes of their secretory power. The seminal fluid, under such circumstances, is very thin, almost liquid, and composed of water and mucus with a minute quantity of albumen, in which the microscope fails to detect animalcules, or, if any be present, they are feeble and deformed. Injury of the back of the head and of the cerebellum, the seat of the instinct of propagation, often effectually arrest the development of spermatozoa; and similar effects have occasionally followed upon apoplexy, paralysis, and other maladies of the nervous centres. In some persons the seminal liquor is naturally destitute of fecundating properties. They are as completely sterile, or incapable of procreating, as if they were deprived of the testes and penis. The researches of Goubaux, Gosselin, Follin, Godard, and others show that a retained testicle is, as a rule, incapable of producing spermatozoa, and that, when both organs are in this condition, the individual is incapable of procreation.

It is an interesting fact, especially in a medico-legal point of view, that persons who have been castrated, often, if, indeed, not generally, possess the power of erection a considerable period after the operation, and even the faculty of emission. The fluid, however, that is retained, in such cases, in the deferent tubes and seminal vesicles cannot long retain its fecundating properties, as it must, after a few losses, be entirely deprived of zoosperms.

Dyspermatism, or inability to propel the semen, and thus bring it in contact with the vagina and uterus, may be caused, 1st, by mechanical obstruction to emission; 2dly, by defective physical conditions of the penis; 3dly, by imperfect erections; 4thly, by want of power in the ejaculatory muscles; 5thly, by hypospadias and epispadias; and, 6thly, by incoordinated action between erection and ejaculation.

1st. Under the first head of causes of dyspermatism may be enumerated stricture of the urethra, polypoid growths, and the presence of foreign bodies. Persons thus affected may copulate, but, if the obstacle is at all considerable, the semen remains in the canal behind the seat of the obstruction, or it flows back into the bladder, and thus fails to reach its destination. Sometimes the obstacle is seated in the deferent tubes, in the seminal vesicles, or in the ejaculatory ducts, occasioned by inflammation and its consequences, as in disease and injury of the testicles, bladder, prostate gland, and probably, also, of the rectum. Several cases of complete dyspermatism have come under my observation from injury inflicted upon the ejaculatory canals in the operation of lithotomy. The individuals were able to copulate, but unable to emit.

An imperforate condition of the prepuce may effectually arrest the flow of semen. A similar effect may be produced by the presence of calculi, formed in a sac of this muco-cutaneous membrane attended with partial occlusion of its natural orifice.

2dly. Complete dyspermatism must necessarily exist in all cases of absence of the penis, whether congenital or accidental. Extreme brevity of the organ, vicious direction, and various morbid growths, may all more or less interfere with the successful propulsion of the seminal fluid.

3dly. Imperfect erections may depend upon various causes, physical as well as mental, and may exist in such a degree as to prevent thorough and efficient ejaculation.

4thly. Ejaculation is effected under the influence of a reflex action, and cannot be properly performed unless the muscles which are concerned in its production are in a sound, vigorous condition. Whenever these muscles—the seminal, perineal, and urethral—are disabled, whether by disease of the parts themselves, or of the general

system, as in apoplexy, or paralysis, or by external injury, as a blow, fall, or kick upon the perineum, anus, scrotum, penis, or hypogastrium, ejaculation will either be imperfect, or altogether impracticable.

5thly. Hypospadias and epispadias are generally considered as causes of dyspermatisms only when the urethra opens very far back. I am of opinion, however, that these malformations may occasionally interfere with ejaculation even when they are limited to the anterior extremity of the penis, especially as the organ, under such circumstances, is often not only remarkably short, but so greatly curved as seriously to impede copulation. Many years ago I saw an elderly colored man, the father of eight children, in whom the urethra opened immediately in front of the scrotum. Persons affected with exstrophy of the bladder are susceptible of erections and emissions, but are generally both impotent and sterile.

6thly. Dyspermatisms may be occasioned by a want of consentaneous action between erections and emissions; that is, ejaculation may not occur until after the penis has become perfectly flaccid, and, consequently, incapable of projecting the seminal fluid to the requisite distance. Such an effect may be produced by various causes, both mental and physical. On the other hand, the emission may occur prematurely, from excessive morbid sensibility of the penis the moment the organ is brought in contact with the vulva.

CHAPTER XIX.

DISEASES AND INJURIES OF THE FEMALE GENITAL ORGANS

SECT. I.—AFFECTIONS OF THE UTERUS.

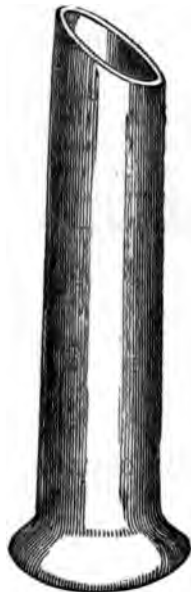
EXAMINATION AND MODE OF MEDICATION.

WHEN the object is to determine the position of the uterus, the exploration should be made with the finger, well oiled and introduced into the vagina, as the woman is standing up before the surgeon, who supports himself upon his knee, or sits on a low stool. In this manner, the finger, moved about in different directions, readily detects any displacement, whether it affects its neck, body, or fundus. If the patient coughs while in this posture, the effect produced by the concussion of the diaphragm and abdominal muscles upon the dislocated viscus is easily appreciated, at the same time that any change in its bulk may be ascertained by the touch, as this variety of exploration is called, and also the extent and degree of the morbid sensibility that may exist. The examination will always be more satisfactory if the bowels be previously well opened and strong pressure be made with the other hand immediately above the pubes. In very thin subjects unaffected by enlargement of the womb the finger in the vagina may be brought almost in contact with those on the outside. Very frequently important information may be acquired by the introduction of the finger into the rectum. Retroversion of the uterus, ovarian dropsy, and various pelvic tumors, are often better diagnosticated in this way than in any other.

When the design is to inspect the mouth and neck of the uterus, or this organ and the vagina, the patient is placed upon her back, across the bed, her feet resting upon its edge, where the breech should also be, the limbs being raised and widely separated from each other. A sheet, with a small hole in the centre, is thrown over the person, which must never be exposed in any case. Sometimes the patient lies on her side, close to the edge of the bed, with the limbs well flexed upon the pelvis, and the body well doubled up. Whatever posture be adopted, there should always be a clear light, that of the sun being superior to any other. The index and middle fingers of the left hand are placed against the orifice of the vagina, near its superior extremity, when the speculum, properly warmed and oiled, is gently and slowly passed along the tube as high up as the mouth of the uterus, which, if not too large, often projects directly into it, thus affording a complete view of its condition. The speculum which I have long been in the habit of using is the cylindrical, fig. 645, about six inches in length, and of a slightly conical shape, to facilitate its introduc-

tion. In order to meet the various contingencies that arise in practice, several such instruments, of progressively increasing size, should be at hand. The trivalve speculum is also an excellent contrivance; but, in displacements of the womb, in vesico-vaginal fistule, and in various operations requiring full exposure of the parts and protracted manipulation, the speculum of Dr. J. Marion Sims, fig. 646, deserves a decided preference. Under similar circumstances the self-retaining instruments of Bozeman and Hough, the latter of which is represented in fig. 647, afford great

Fig. 645.



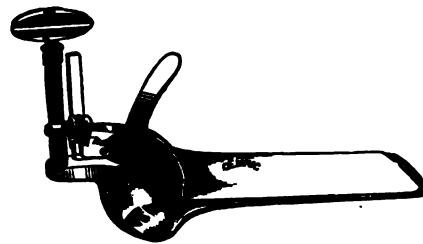
Cylindrical Speculum.

Fig. 646.



Sims's Speculum.

Fig. 647.



Dr. J. Stockton Hough's Self-retaining Speculum.

facilities. Professor Miller, of Kentucky, prefers a cylindrical speculum, bevelled at each extremity, in opposite directions, so as to shorten one of its sides, which is turned towards the pubes during the introduction; an arrangement which not only admits more light, but affords easier access to the mouth of the organ.

Whatever instrument be used, a proper probe should always be at hand. For ordinary purposes, none answers better than the one delineated at p. 411; but when the object is to explore the cavity of the uterus, or to replace this organ, Simpson's sound, fig. 648, should be selected, or that recommended by Dr. Miller, which is a

Fig. 648.



Simpson's Sound.

good deal more curved than that of the Scotch obstetrician, and, therefore, better adapted to the rectification of some of the malpositions of the viscus. Another contrivance, one that will be found of great service, is a soft sponge mop, for wiping away the secretions, so as to afford a clearer view of the affected structures. For pulling down the uterus during operations, various kinds of sharp hooks, thrust deeply into the neck of the organ are used.

Leeches are applied to the uterus and to the upper portion of the vagina by placing the animals in a speculum, the parts having previously been well cleaned with water, the number varying according to the amount of the morbid action, and the condition of the general system. A good average is from three to five, which often cause a very copious flow, the bleeding frequently continuing for many hours

after the animals have dropped off. When the flow is too abundant the use of Monsel's salt may be required.

In congested, inflamed, ulcerated, and enlarged conditions of the uterus, blood is often advantageously drawn by *scarification*. The operation is usually performed with an ordinary sharp-pointed bistoury with a long handle, passed lightly over the affected surface at several points of its extent. Or, instead of this, the interior of the cervix may be incised, the cuts, two or three in number, being carried into the muscular substance. In hypertrophy of the neck of the organ, great and rapid relief frequently follows the use of punctures, the knife being thrust into the uterine tissues at numerous points to the depth of the twelfth of an inch. The flow will be the more abundant, if, previously to the use of the knife, the cervix be drycupped with the hard rubber exhauster, sketched in fig. 649, introduced through the speculum.

Fig. 649.



Hard-rubber Cylinder for Drycupping the Neck of the Uterus.

The most common *caustic*, or, rather, antiphlogistic applications that are made to the uterus are nitrate of silver, either in substance or solution, and acid nitrate of mercury, either pure or weakened. To insure the efficiency of these applications, they should be made with the aid of the speculum, directly to the affected surface, care being taken not to use them too freely, too often, or too strong. The lightest possible touch frequently answers the purpose of an antiphlogistic agent. When the actual canter is employed, a wooden speculum is necessary, to protect the parts from the heat, and to prevent the fluids from coming in contact with the vagina.

Cauterization of the cavity of the uterus may be effected with solid nitrate of silver, provided the disease for which it is practised is not situated very high up. When this is the case it will be safer to use this substance in solution, applied upon a mop, the strength varying from ten to forty grains, according to circumstances. Injections of the cavity of this organ are not always free from danger, however cautiously used. Indeed, a considerable number of cases have been reported in which they proved fatal, from the entrance of some of the fluid into the peritoneal cavity. It has been shown that even injections of simple tepid water are liable to be followed by severe shock and inflammation.

Inflammation of the uterus and vagina is often rapidly relieved by means of *tampons* of cotton, charpie or lint, medicated with various kinds of fluids, as a solution of tannic acid in glycerine, Goulard's extract, acetate of lead, alum, or subsulphate of iron. The proper plan is always to begin with a weak solution of these substances, their strength being gradually increased as the treatment proceeds. Employed too strong at first, they are liable to cause pain and to aggravate the disease. The dressing should be repeated at least three times in the twenty-four hours, especially if there be much discharge.

Dr. John J. Black, of New Castle, Delaware, has used with great advantage medicated suppositories in vaginal affections. From numerous experiments performed at the Philadelphia Hospital, with various articles, he has been led to give a decided preference to subsulphate of iron, in saturated solution, incorporated with cocoa butter and simple cerate with the addition of a small quantity of morphia. Retention is effected, if need be, with the aid of a compress and T-bandage.

Perfect cleanliness of the uterus and vagina, in disease, can only be secured by the use of the *syringe*, of which there are a great many before the profession; few, however, that combine all the necessary qualities of such an apparatus. To answer the purpose properly, the instrument should be a globular gum one, with a nozzle four inches in length, perfectly straight, nearly half an inch in diameter, and perforated with numerous large foramina, after the fashion of the common watering spout. The injection may be administered by the patient herself, as she lies on her back, over a bed pan, or while she is sitting up, care being taken to direct the nozzle upwards and backwards towards the coccyx, and to use considerable force, in order to bring the fluid, which may be either simple or medicated, in contact with every

portion of the affected surface. The injection, whatever may be its character, should always be tepid, inasmuch as cold is often productive of great distress, both local and general, especially in nervous, anemic women.

Anodyne injections are occasionally applied for relieving pain of the vagina and uterus; but, unless they be performed while the pelvis is thoroughly elevated, the fluid soon runs off, and no benefit is received. Besides, the proceeding is both awkward and inconvenient. I have, therefore, myself long since abandoned it, and used, instead of it, cotton or lint, rolled up into a ball, steeped in a strong solution of morphia, or pure laudanum, and introduced by means of the finger, probe, or forceps, in immediate contact with the mouth of the uterus.

Dilatation of the cavity of the uterus may be required to bring on premature labor and to facilitate the removal of morbid growths, the substance generally employed being a compressed sponge tent, inserted with a long pair of forceps with serrated blades. In this way the object may often be attained in a few hours, especially if a series of dilators be used in rapid succession. When it is designed to increase the size of the canal of the organ for the purpose of promoting conception, the sea-tangle tent answers every purpose, and is, in many respects, preferable to the sponge tent. Retention is favored by plugging the vagina with a mass of cotton, removal being effected through the speculum in from twelve to twenty-four hours. No force must be used in the operation, otherwise it may cause peritonitis, and even death. In a case in the hands of Professor Gaillard Thomas, the woman perished from tetanus. Strict recumbency should always be observed, not only during the sojourn of the tent, but for a day or two after.

The surgeon is sometimes obliged to remove a *pessary* from the vagina, owing to the pain, inflammation, ulceration, and discharge which it so often provokes. The operation is by no means always an easy one, especially if the instrument is globular and of large size, when it may be exceedingly troublesome and embarrassing. The ordinary ring, flat, or horse-shoe pessary may usually be extracted with the finger. When unusual difficulty is experienced, recourse may be had to the lithotomy-forceps; and a similar expedient will often be necessary in retention of the globular pessary. Cases have been witnessed where the suffering from attempts at extraction was so intense as to call imperatively for the use of chloroform.

It seems difficult to understand why there should still be such a fondness for the pessary, when it is so often productive of mischief, and when the very principles upon which its use is founded are so erroneous. I am sure that no one who has ever witnessed the happy effects of a well-constructed abdominal supporter would exchange such an apparatus for the most unexceptionable pessary that could be devised. The one is clean and comfortable, the other filthy and painful; the one takes the weight of the viscera off the uterus and enables the female to walk and exercise without inconvenience; the other, without supporting the uterus, compresses the vagina, bladder, and rectum, and renders progression often difficult, if not impossible.

MALPOSITIONS.

Of the various malpositions to which the uterus is liable, the most common are retroversion, anteversion, prolapse, and inversion.

1. In *retroversion*, fig. 650, the orifice of the uterus is tilted up against the pubic symphysis, the fundus being thrown downwards and backwards, so as to form a tumor between the vagina and the rectum. Thus the axis of the organ is totally reversed relatively to its natural situation within the pelvis. The displacement is very common in the unimpregnated state, and is also occasionally met with during pregnancy, especially between the third and fourth months. It generally occurs in consequence of the relaxation of the ligaments of the uterus, and of the engorged condition of this organ, rendering it, as it were, top-heavy, and thus favoring its descent against the rectum. For these reasons, the accident is often met with soon after delivery, at a time when the body of the uterus

Fig. 650.



Retroversion of the Uterus.

accident is often met with soon after delivery, at a time when the body of the uterus

is unusually large and vascular, and, therefore, incapable of sustaining itself in its natural position.

Retroversion of the womb is attended with a sense of weight and dragging in the pelvis and groins, pain in the sacrolumbar region, frequent desire to pass water, with almost constant uneasiness in the bladder, and difficulty in defecation. The general health is variously affected, and there is usually more or less leucorrhœa. In the worst forms of the disease, the patient often suffers from retention of urine. The retroverted organ is always easily detected with the finger, its orifice lying immediately behind the pubic symphysis, while the body forms a hard, globular mass, resting upon the lower part of the rectum. The affection is liable to be confounded with abscess of the pelvis, polyp of the uterus, ovarian tumors pressing down the posterior wall of the vagina, and stricture of the lower bowel.

The treatment is strictly antiphlogistic, consisting of rest in the recumbent posture, light diet, purgatives, astringent injections into the vagina, and the application of leeches to the uterus. Reposition is effected by the sound, carried into the cavity of the womb, aided by pressure against the body and fundus of the viscus with the finger in the vagina or rectum. In the milder cases of displacement, the reduction may often be readily effected through the agency of the colpeurynter, carried high up in the vagina, and then forcibly distended with air or water. When the uterus has become firmly adherent to the surrounding parts, the disease may be regarded as irremediable, although considerable relief may follow the use of a stem pessary.

2. *Anteversion*, fig. 651, is a displacement precisely the reverse of the preceding, the fundus of the womb being carried forwards on the urinary bladder, and the mouth backwards towards the rectum and the hollow of the sacrum. It rarely occurs during pregnancy, and is almost always associated with hypertrophy of the uterus. Anteversion is sometimes produced by morbid adhesions between the organ and the peritoneum, which have the effect of forcing it out of its normal position. The patient experiences more or less distress, as a sense of weight and bearing down in the pelvis, and dull, heavy, aching pains in the lower part of the back. Leucorrhœa also usually exists, and there is often marked disorder of the general health, as shown by various nervous and anomalous phenomena. The bladder and rectum are frequently seriously incommoded by the pressure of the dislocated organ. The precise nature of the affection is always readily distinguished by digital examination. The treatment is conducted upon the same general principles as in retroversion. When the ordinary means fail, elytrorraphy may be resorted to, the operation, as practised by Sims, consisting in the removal of two horizontal strips of mucous membrane from the anterior wall of the vagina, separated about one inch and a half from each other, and united by wire sutures, retained for a fortnight to three weeks. The object is to shorten the vagina, and thus draw the neck of the uterus towards the pubic symphysis.

In both of the above forms of displacement, the patient should observe recumbency for several weeks after the reduction, and, for a long time, pay great attention to her bowels and diet. Immediately after the operation is over, she should put on a uterine supporter, which should never be left off for a moment, when she is in the erect posture, until there is reason to believe that the parts have entirely regained their original situations.

3. *Prolapse* of the uterus occurs in two varieties of form, the partial and the complete. In the latter, known as *procidentia*, the organ projects beyond the vulva, forming a tumor between the thighs, attended with complete inversion of the vagina. In fact, the mass constitutes a genuine hernia, consisting of the uterus, either in whole or in part, of the anterior wall of the bladder, of the involved vagina, and often also of a portion of the small intestine. The affection may be produced by mere relaxation of the genital apparatus and the adjoining parts, with an engorged condition of the uterus, thus materially increasing the weight of the organ, but the

Fig. 651.



Anteversion of the Uterus.

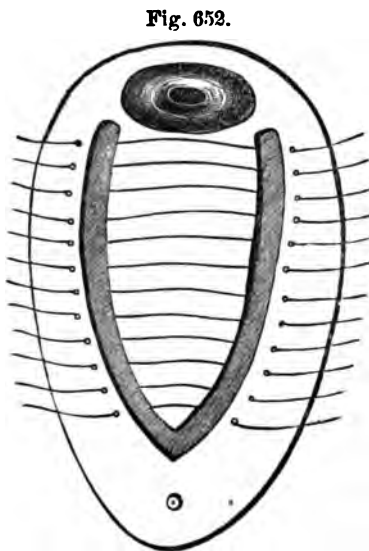
immediate cause is generally a severe strain during defecation, micturition, or parturition. Serious prolapse is occasionally induced by the pressure of a pelvic tumor, by habitual distention of the bowels, and by the presence of a morbid growth of the uterus itself.

The symptoms of prolapse vary. Even the more simple forms of the affection are always attended with more or less muco-purulent discharge, a feeling of weight in the pelvis, dragging sensations in the groins and hypogastrium, pain in the sacro-lumbar region, and disorder of the general health. The diagnosis is easily determined by a digital examination while the patient is in the erect posture. The neck of the uterus will generally be found towards the sacrum, immediately in front of the rectum, and there will be no difficulty in forming an idea as to its distance from the vulva. The existence of procidentia is denoted by the peculiar shape and reducibility of the tumor, and by the central situation of the orifice of the uterus.

For the more simple forms of prolapse, the most suitable treatment is the constant use of a well-adjusted supporter, the pad, which should be rather broad, and of an ovoidal shape, resting upon the hypogastrium, so as to hold up the abdominal viscera, and thus prevent them from pressing too much upon the womb. The apparatus need not be worn at night, but it should always be put on in the morning before the patient gets out of bed. When the disease exists in a very aggravated degree, it may be necessary, in addition, to employ a stem pessary, made of silver with a perforated cup for the accommodation of the neck of the uterus. The pressure thus exerted lifts the organ out of its abnormal position, and enables it to regain its natural relations. Great benefit generally accrues from the steady use of astringent injections, a soluble condition of the bowels, a concentrated diet, and rest in the recumbent posture, with the frequent application of leeches to the neck of the uterus, to relieve engorgement and induration. The ordinary pessary, of whatever shape or substance, is a filthy instrument, provoking pain and discharge, and generally does more harm than good.

The chief remedies in ordinary procidentia are leeches and scarification, astringent injections, protracted recumbency, and the use of a stem pessary with an abdominal supporter.

When the neck of the uterus is greatly elongated, thickened, and indurated, the best plan is to excise it, in order to relieve the organ of a portion of its weight. In the more rebellious forms of the complaint, attended with inordinate dilatation of the vagina, *elytrorrhaphy* may sometimes be advantageously employed, the process of Sims, represented in the annexed cut, fig. 652, being the one usually adopted. This consists in removing with a tenaculum and curved scissors on each side of the vagina, a strip of mucous membrane, from one-third to half an inch in width, commencing immediately above the neck of the bladder, and extending nearly as high up as the uterus, the two raw surfaces exhibiting somewhat of a horse-shoe configuration. The edges of the wound are tacked together by silk or wire sutures, retained until they are completely united. The object of the operation is to contract the canal of the vagina so that the uterus may afterwards be more easily kept in place. The adhesions, however, not unfrequently give way, thus frustrating its design. The procedure has been modified by Emmet and Thomas, but it is not



Sims's Operation of Elytrorrhaphy; Sutures in Place.

known with what results. Laugier and Kennedy have attempted, but unsuccessfully, to produce a similar effect with the hot iron.

When the above treatment fails, the only resource is closure of the orifice of the vagina by paring the labia in the greater portion of their extent, and uniting the vivified surfaces with the interrupted suture. The operation, also frequently unsuccessful, constitutes what is called *episiorrhaphy*.

4. In *inversion* of the uterus, the viscus is turned inside out. It is generally attended with more or less prolapse of the body of the organ, and seldom happens except during delivery of the after-birth, from traction upon the cord, or the forcible removal of some growth from its interior, as a polyp or myomatous tumor. The lesion presents itself in three principal degrees. In the first, the fundus falls down nearly to the mouth of the womb, where it is arrested; in the second, it passes beyond this point for half or more of its length; in the third, the whole organ escapes at the inferior orifice. In the second case it is obvious that the body and fundus may be compressed, or strangulated, by contraction of the neck. The complete form of inversion of this organ is well shown in the annexed drawing, fig. 653, from a specimen in the cabinet of the late Professor Meigs.

The diagnosis of inversion is seldom difficult. The most important phenomena are the existence of a pyriform tumor larger below than above, and a constant sanguinolent discharge, often so profuse as seriously to undermine the general health, causing anemia, palpitation of the heart, and various other disorders denotive of loss of blood. The hemorrhage is often severe and copious. This occurred in 49 out of 102 cases analyzed by Dr. Charles A. Lee. The affection has occasionally been mistaken for a polyp, and, conversely, a polyp has been mistaken for an inverted uterus. Errors of this kind have occurred in the hands of the ablest obstetricians, as Velpeau, Ley, and Rigby, and cannot always be avoided even by the most careful and patient investigation, so closely do these tumors sometimes resemble one another.

The reduction in the more simple forms of inversion of the uterus is often sufficiently easy, especially if attended to immediately after the occurrence of the accident. In chronic cases, on the contrary, it is very difficult and sometimes even impracticable. The efforts at replacement should always be made with the aid of an anæsthetic, while the patient is on her back, the bladder and bowels having previously been well emptied. In performing the operation the inverted organ should be firmly grasped with the hand in the vagina, and equably and thoroughly compressed, at the same time that it is pushed gently and steadily upwards. Care must be taken in this stage of the procedure not to put the vagina too forcibly on the stretch, otherwise it may be lacerated. The danger of such a mishap will be much diminished, and the reduction greatly facilitated, if counterpressure be made with the hand applied immediately above the pubes. By these efforts, steadily and perseveringly continued, the body of the uterus is gradually unfolded, and the resistance at its neck progressively lessened, until, at length, after a period varying from a few minutes to several hours, the parts resume their natural position. The first instance in which this mode of reduction succeeded, was that of Professor Quackenbush, of Albany, soon followed by one by Professor J. P. White, of Buffalo, of fifteen years' standing, and one by Dr. Tyler Smith, of London, of nearly equal duration. Noeggerath, Sims, Emmet, and others have since been equally fortunate. Dr. Tyler Smith effected the replacement very slowly with the aid of an India-rubber air-ball, conjoined with manipulation for ten minutes at a time twice a day for upwards of a week. Professor White, who has had altogether nine successful cases, and who believes that all cases of inversion can be reduced without qualification as to their duration, has devised what he calls a uterine repositor for facilitating replacement. The instrument is described and figured in *The American Journal of the Medical Sciences*, for April, 1872. Dr. T. Addis Emmet in two instances succeeded, not, however, without great difficulty, by grasping the womb as near as possible at its neck, and then, by pressing steadily upwards, unrolling first that portion of the tumor which was inverted last, the extremities of the fingers acting as a wedge laterally. The manœuvre was greatly facilitated by the application of the other hand to the lower part of the abdomen. In very obstinate cases, the reduction,

Fig. 653.



Inversion of the Uterus.

by manipulation, will generally require a relay of assistants, on account of the excessive fatigue experienced by the compressing hand, almost depriving it of power. In the first edition of this work, issued in 1859, I suggested that the reduction in this affection, especially in cases of long standing, might be greatly facilitated by a slight vertical incision on each side of the neck of the tumor, where the chief obstacle ordinarily lies, the principle being the same as in the operation for paraphimosis. No opportunity has occurred to me to put this idea in practice, but Dr. Barnes, of London, has recently reported several cases in which he successfully employed it.

When the tumor is hopelessly irreducible, it is not only a source of mechanical inconvenience, but of almost incessant hemorrhage, and of muco-serous discharge, draining the system of blood, and keeping the woman constantly at death's door. Under such circumstances, as a dernier resort, amputation is occasionally practised. The operation, however, is generally fatal, the patient dying from shock, hemorrhage, peritonitis, or pyemia. In an instance in my hands, many years ago, death occurred within two days from inflammation, and in another in which I assisted Professor Miller, the woman perished from hemorrhage in less than three hours. From the results of these two cases, I should certainly have no desire to repeat the operation. Of 14 cases of excision analyzed by Dr. Lee, only 4 are said to have died. No doubt many fatal cases of this operation have occurred that have never been reported, and it is, therefore, impossible to form anything like a correct estimate of its mortality.

Of 32 cases of inverted uterus removed by ligature, only 4, or 1 in 8, according to Dr. Lee, died. The operation would, therefore, seem to be much safer than excision. The danger of the procedure is materially lessened by tightening the cord gradually, and also occasionally relaxing it, if it cause much local and general disturbance. When the strangulation is completed, the necrosed portion of the organ should be removed with the knife, to prevent fetor and irritation. There are no statistics of the ablation of inverted uterus with the *écraseur*; nor is it possible, in the existing state of the science, to institute a comparison in regard to the relative safety of the operation as performed by this instrument and by the ligature. In a case of inverted uterus complicated with an intramural myomatous tumor, reported, in 1871, by Dr. Thomas Hay, of this city, removal was successfully effected with the *écraseur*, the patient, who was thirty-three years old, making a rapid recovery.

Experience has shown that a woman laboring under this affection may sometimes live in comparative comfort, and ultimately die, after the lapse of many years, of some other disease. In a case observed by Dr. Lee, the nature of the complaint had remained undetected for a quarter of a century. The woman was then forty-five years of age; and, menstruation ceasing shortly afterwards, there was no further hemorrhage, and the general health improved so rapidly as to render surgical interference unnecessary.

WOUNDS.

The unimpregnated uterus, from its small size and its concealed position in the pelvic cavity, is seldom the subject of wounds, but such accidents may readily happen in the gravid condition of this organ, especially after it has ascended above the pubes. The lesion is usually inflicted with a knife or sharp piece of wood, and several instances have been reported in which it was caused by the horn of an infuriated cow. Gunshot injuries of the uterus are uncommon. The Cæsarean section affords the best example of an incised wound of this organ.

It would be difficult, if not impossible, to diagnosticate a wound of this organ in its empty state, but such a lesion may, in general, be easily detected during pregnancy, by the escape of the amniotic liquor and the profuseness of the hemorrhage; besides, the accident might be attended by such an amount of injury of the walls of the abdomen as to afford an opportunity for direct inspection, as, for example, when a woman has been gored by a cow, or the pelvis has been ripped open by machinery or by the teeth of an animal.

The great sources of danger in wounds of the uterus are hemorrhage and peritonitis. The former, which may be immediate or secondary, may depend upon the injury sustained by the organ itself, or upon mischief inflicted upon the fetus, or

the fœtus and placenta. In a case related by Devaux, the woman speedily perished from copious hemorrhage caused by the knife having penetrated the child's chest. Death from peritonitis usually comes on at a period varying from three to five days. If it were not for these occurrences, the probability is that few patients would die from such wounds, as they often readily unite by the first intention, as is shown in the Cæsarean operation.

The treatment is governed by the general principles of practice. If the gravid organ has been penetrated, its contents should be removed either through the abnormal opening or by the natural route, after which the fluids in the pelvic cavity should be carefully sponged up, and the rent in the abdomen approximated by the interrupted suture, in the same manner as in wounds of the intestines. The opening in the uterus promptly closes of its own accord. The after-treatment is strictly antiphlogistic. The urine is drawn off from time to time with the catheter.

INFLAMMATION AND ULCERATION.

The uterus is liable to inflammation, both in the married and in the single female, but much more frequently in the former than in the latter. The disease may attack any portion of the organ, or it may be limited to the lining membrane, the parenchymatous substance, or the peritoneal covering, or all these structures may be involved simultaneously, together with the venous and absorbent trunks.

Inflammation of the lining membrane—the *endometritis* of authors—occurs in two varieties of form, the acute and the chronic, and may be limited either to the neck or the body of the organ, although in many cases it is diffused over both. It is characterized by the same phenomena as inflammation of the mucous textures in other situations. The redness, which is of a deep shade, is often spread over a large extent of surface, and may, in violent cases, be accompanied by small ecchymoses, with an escape of blood on pressure. The mucous follicles, especially those about the mouth of the uterus, are more or less enlarged, and there is usually a very notable increase of the natural secretion. In some instances pus is deposited, and continues to be discharged for a considerable period. An effusion of plastic matter is also sometimes observed, but chiefly when the disease invades the lining membrane of the body of the organ.

Abscess of the uterus, a very rare disease, may arise from various causes, of which the most common, perhaps, is external injury inflicted during parturition. It is characterized by severe pain, of a throbbing, pulsatile character, and the ordinary phenomena of inflammation, local and constitutional, in an aggravated degree. The diagnosis can only be determined with the speculum. Relief is afforded by an early and free incision.

Dr. Graily Hewitt has reported a unique example of abscess of the womb, complicated with a traumatic aneurism of the uterine artery, which freely communicated with the abnormal pouch, one of large size, and thus gave rise to several severe attacks of hemorrhage, in one of which the woman died.

Ulceration of the uterus is most common between the ages of thirty and forty, in married women. It usually attacks the lips and neck of the organ, and exhibits every variety of form, from the slightest abrasion, merely involving the mucous lining, to a cavity several lines in depth. The resulting sore may be of a circular, oval, or linear shape; or it may present the appearance of a crack, chape, or fissure. Its edges are sometimes very abrupt, as if a depression had been made into it with a punch. The bottom of the ulcer is smeared with unhealthy pus, incrustated with lymph, or studded with granulations. The surrounding structures are red, tender, and often quite indurated. In cases of long standing, or of unusual severity, the lower extremity of the uterus is excessively engorged, considerably enlarged, and greatly altered in its figure, often exhibiting a knobbed, clubbed, or pouting appearance. Occasionally the affected structures, instead of being indurated, are abnormally soft, or hard at one point and soft at another. In the more aggravated forms of ulceration, the organ increases in its weight, and thus becomes a cause of its own prolapse, by the dragging effects upon its ligaments. The concomitant discharge is subject to the greatest possible variety, both as it respects its quality and quantity. Thus it may be thick and yellow, thin and sanious, bland or irritating, scanty or abundant, mixed with mucus, free from odor or more or less fetid.

Ulcers of the uterus may be acute or chronic, simple or specific. The simple

sore usually arises without any assignable cause, and often continues for months and years, making, perhaps, in the mean time very little progress. The syphilitic ulcer is usually distinguished by its excavated character, its spreading tendency, and the copper-colored appearance of the adjacent parts.

Inflammation and ulceration of the uterus often coexist with vaginitis. The most common symptoms are, a discharge of thick, yellow, purulent, or muco-purulent matter, a feeling of weight and fullness in the lower part of the pelvis, tenderness on pressure of the hypogastrium, pain and aching in the sacrolumbar region, and dragging, sickening sensations in the groins and back, especially during exercise. The general health, at first unaffected, is sure to suffer as the disease progresses. The menstrual function is apt to be disordered; and, although conception is not impossible, even when there is considerable ulceration, yet a female thus affected is extremely liable to abort or miscarry. The diagnosis can only be satisfactorily determined by a thorough exploration with the speculum.

The treatment of inflammation of the mucous membrane of the uterus, in its milder forms, is generally very simple, the disease usually promptly yielding to the ordinary antiphlogistic remedies, as light diet, an active purge, recumbency for a short time, and injections of acetate of lead, Goulard's extract, tannic acid, alum, or zinc. If the disease is obstinate, or complicated with ulceration, a few leeches may be necessary, followed by the application of the solid nitrate of silver, or, what I prefer, the dilute acid nitrate of mercury, repeated every fourth or fifth day, the parts being frequently syringed with cool or tepid water, medicated with some astringent substance. Tampons of cotton, charpie, or lint, wet with tannic acid and glycerine, in the proportion of two drachms to the ounce, and retained in immediate contact with the inflamed surface, often rapidly reduce the morbid action. They should be changed at first every twelve hours, and afterwards once a day. When leeches cannot be obtained, recourse is had to scarification. If the caustic be used too often or too freely, harm instead of benefit will result, and the case be much longer in getting well. The patient should be rigidly recumbent during the treatment. If the inflammation extends into the cavity of the uterus, gentle cauterization will be required, followed, after the violence of the morbid action is subdued, by the use of small medicated tents inserted once every four-and-twenty hours.

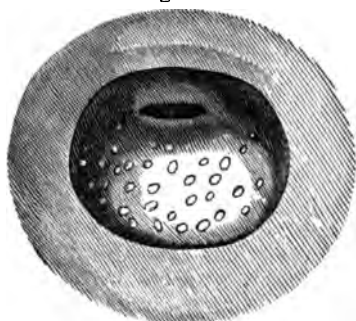
A *granular* condition of the neck and mouth of the uterus occasionally exists, the mucous membrane being thickly studded with bodies similar to those which are so frequently found on the eyelids. The disease, which is often associated with ulceration, is generally a consequence of chronic inflammation, and is always attended with more or less muco-purulent discharge. The best local remedy is chromic acid, used in the same cautious manner as when applied to warty excrescences of the penis and vulva, repetition being effected every fourth or fifth day.

Another effect of chronic inflammation of the uterus is an extraordinary development of its *mucous follicles*, particularly conspicuous about the mouth and lips of the organ, where the glands are sometimes as large as a hemp-seed, or even a small pea, dense, almost gristly, and of a white, grayish color. The intervening structures are generally tumid, red, morbidly sensitive, and disposed to bleed. Occasionally the enlarged glands are transformed into cysts of considerable size, filled with a pale,

tremulous substance, easily removed by pressure. The appearance of these enlarged follicles, in the different stages of their progress, is well shown in fig. 654. The disease, which is a form of acne, is always attended with induration and thickening of the neck and lips of the uterus and a tolerably profuse discharge of muco-purulent matter. The most effectual treatment is repeated and thorough scarification of the affected structures, along with leeching and the application of solid nitrate of silver; or, what I have generally found more beneficial, the pure tincture of iodine.

Inflammation of the *body* and serous covering of the uterus is most common in females during the first eight or ten days after parturition. It sometimes betrays an epidemic tendency, and

Fig. 654.



Follicular Disease of the Uterus.

rapidly passes into suppuration, softening, or even gangrene. The pus that is poured out, in such cases, may be situated in the parenchymatous structure, in the uterine cavity, the subserous cellular substance, between the folds of the broad ligaments, or, finally, in the venous and absorbent trunks, or simultaneously in all these parts. In most of these localities it occurs in the form of isolated corpuscles; but cases are observed in which it is collected into little abscesses, which, sooner or later, burst into the vagina, rectum, pelvis, or urinary bladder. The pus is generally blended with a good deal of lymph, and is sometimes highly offensive.

The lesion may originate in, and be limited to, the veins, constituting what is called uterine *phlebitis*; in the great majority of cases, however, the parenchymatous structure participates in the inflammation, assuming a dark, livid aspect, at the same time that it loses its natural consistence. Serum and pus may also be found in the subserous cellular tissue; while the peritoneal investment is sometimes covered with thick patches of lymph. The veins themselves are always much enlarged, and filled with pus, clots of blood, or plugs of plasma. The disease often extends along the venous trunks of the pelvis to those of the abdomen, or even to those of the inferior extremities; and very frequently the absorbent vessels are similarly circumstanced, being greatly augmented in volume, and infiltrated with enormous quantities of purulent matter.

The causes of uterine *phlebitis* are not always very evident. In some cases it appears to result from violence done in the extraction of the placenta, while in others it may be traced to the effects of cold and moisture, to irregularities of diet, or to some peculiar noxious condition of the atmosphere. In general, the disease exhibits all the evidences of erysipelas, or pyemia, both as it respects its pathology and symptoms. Ushered in by rigors, or chills alternating with flushes of heat, it soon assumes a typhoid character, the pulse becoming small and frequent, the tongue dry and parched, and the surface covered with profuse, clammy sweats. The abdomen is exquisitely tender on pressure, the stomach is irritable, the mind wanders, the milk is suppressed, and the lochial discharge is excessively fetid.

The treatment must be conducted upon the same principles as in pyemia and erysipelas. Great attention is paid to cleanliness and ventilation; free use is made of deodorants; the syringe is employed three or four times a day; leeches and fomentations are applied to the abdomen; the bowels are locked up with opium, to prevent irritation of the peritoneum; and support is afforded by quinine, iron, milk punch, and nutritious broths and soups.

HYPERTROPHY.

Hypertrophy of the uterus occurs in two varieties of form, the general and the partial. In the first, the affection is usually most conspicuous in association with myomatous tumors, in which it is sometimes truly enormous. Thus, in a specimen in my possession, the walls of the organ are nearly two inches in thickness, and of a firm, dense consistence, grating under the knife. Its cavity is of extraordinary size, and several small tumors are seen projecting from its outer surface. The hypertrophy is sometimes confined to the lips of the uterus, which, especially the anterior, become thick, dense, and stumpy. The immediate cause of hypertrophy of the uterus, is, doubtless, in most cases, chronic inflammation attended with interstitial new formations. The disease often continues for a long time without apparently any disposition either to advance or to recede. The diagnosis is readily ascertained by touch and inspection. If the organ is unusually large, it may be distinctly felt in the hypogastric region, and may occasion serious inconvenience by its weight and pressure. The affection must not be confounded with carcinoma.

The treatment must be conducted upon general antiphlogistic principles; by leeches, scarification, and cauterization of the neck and mouth of the organ, and by proper attention to the diet, bowels, and recumbency. The exhibition of mercury will be of no particular avail, except in so far as it may assist in improving the general health; but advantage will be derived from the internal use of iodide of potassium, and of hydrochlorate of ammonia, in doses of five to ten grains, three times a day.

In partial hypertrophy the disease, affecting chiefly, if not exclusively, the neck of the organ, consists essentially in elongation and thickening of its lips. The enlargement is attended with more or less induration, and usually presents itself as

DYSMENORRHOEA.

Dysmenorrhœa, or painful menstruation, is a very common affection, both in single and in married women, but especially the former. It may depend upon various causes, some of them of a mechanical and others of an ordinary character, as narrow and constricted state of the uterus, the presence of a polyp or myomatous tumor, the effects of cold, ovarian disease, anemia and disorder of the general health, however induced. In many of the cases that have come under my observation, I have been led to believe that it was of a rheumatic character; a view supported by the agonizing lumbago which so generally attends it, and the relief afforded by anti-rheumatic remedies. However this may be, the disease is commonly of an inflammatory character, and is frequently, if not invariably, attended with a discharge of plastic matter and coagulated blood, the proper menstrual secretion itself being very sparing. The membranous formation, which is seldom thick or firm, generally moulds itself to the inner surface of the uterus, and is expelled either piecemeal or entire, the period required for its extrusion varying from a few hours to a number of days.

The treatment is palliative and radical. The former, which has reference to what should be done during the menstrual attack, consists in the free use of anodynes, either by the mouth, hypodermically, or by the rectum, with the application of strong veratria ointment to the sacrolumbar region. If plethora exist blood is taken from the arm, and the system is relaxed by aconite, Dover's powder, and the hip-bath. To prevent a recurrence of the suffering, and afford, if possible, permanent relief, I have found nothing so effectual as the use of the wine of colchicum, in the dose of one drachm in union with a fourth of a grain of morphia, every evening at bedtime, commenced about seven days before the expected period, and perseveringly continued for several consecutive weeks. If the patient is anemic the treatment should be associated with the administration of tonics, as iron and quinine. Great relief generally follows from the application of a large opium and aconite plaster to the sacrolumbar region, frequently renewed. When the affection is dependent upon an unusually tight orifice of the uterus, interfering with the discharge of the menstrual fluid, coagula, or deciduous membrane, the most effectual and speedy remedy is the free division of the stricture, dilatation being afterwards maintained with a suitable tent, inserted from time to time to prevent reclosure, to which there is always a remarkable tendency. The fact that this operation, no matter how thoroughly performed, or frequently repeated, often fails to afford permanent relief, is an indubitable evidence that dysmenorrhœa is not, as some have contended, always due to mechanical obstruction of the womb.

NEURALGIA.

Neuralgia of the uterus is not uncommon, and is occasionally met with very soon after the age of puberty, especially in nervous girls, in connection with dysmenorrhœa. Married women, however, are most subject to it; and it is liable to occur both in the empty and gravid state of the organ, although much more frequently in the former. Sometimes it takes place soon after delivery. Being generally associated with neuralgia in other parts of the body, it is either strictly periodical in its attacks, like the paroxysms of an intermittent fever, or, as is more commonly the case, it shows itself as a persistent affection, liable to frequent exacerbations. The exciting causes are not always appreciable, although usually it is dependent upon disordered menstruation, organic disease of the uterus, vagina, ovary, bladder, or rectum, derangement of the digestive apparatus, or lesion of the cerebro-spinal axis. In many instances it is directly traceable to the influence of malaria, and in that event its attacks are nearly always distinctly paroxysmal, recurring with considerable regularity once or twice a day, or once every other day.

The most prominent symptoms are sharp, darting, or shooting pains in the uterus and pelvic region, extending into the limbs, the back, hip, groin, and abdomen, which, together with the uterus, is often exquisitely tender and sore on pressure. Not unfrequently the pain is of a dull, heavy, aching, gnawing, or burning nature. However this may be, it is always aggravated by fatigue, exposure to cold, disorder of the digestive organs, mental trouble and irregularity of the menses. In most cases it is attended with a bearing-down sensation, as if the uterus were about to be ex-

pelled from the pelvis. I have repeatedly seen cases where the patient was unable, for weeks together, to maintain the erect posture, or even to walk across the floor, on account of the exquisite morbid sensibility of the affected structures.

In the treatment of this affection, which is often exceedingly obstinate, and even intractable, one of the first and most important objects is to remove, if possible, the exciting cause, when the pain will often disappear of its own accord. The diet, bowels, and secretions should claim special attention in every case. In the malarial form of the malady, quinine, either alone or in union with arsenic and strychnia, constitutes the most valuable remedy, and the same articles are frequently of great benefit in the more ordinary attacks. Colchicum, in drachm doses at bed-time, with half a grain of morphia, is also a remedy of much efficacy. During the violence of the paroxysm relief is sought by recumbency, the hot sitz-bath, hot fomentations to the abdomen and genitals, anodyne injections or suppositories, and morphia by the mouth. A cotton tampon saturated with a strong solution of morphia and tincture of aconite in glycerine, and placed in close contact with the neck of the womb, often acts like a charm.

COLLECTIONS OF GAS.

Air now and then collects within the cavity of this viscus, constituting the disease which has been described by pathologists under the name of emphysema, phytometra, and tympanites. How the air is formed is still a disputed point. In many cases it may be distinctly traced to the decomposition of effused fluids, as blood, serum, or pus; in others, it is not unlikely that it is the product of a true secretion from the uterine vessels, brought about by some morbid condition, the precise nature of which is unknown. These accumulations may take place at any period of life, in married females, and is generally an evidence of previous conception. They may also occur in single women, as a result of organic disease. When considerable, they cause the womb to expand and rise up in the abdomen, as in pregnancy, with which it may easily be confounded. After the flatus has existed for several months, the uterus commonly makes an effort to dislodge it, expelling it with a noise somewhat similar to that occasioned in eructation.

The diagnosis is readily established by the peculiar elasticity and resonance of the tumor, the absence of fluctuation, and the occasional escape of flatus from the vagina.

The treatment consists in evacuating the air with the trocar, and injecting afterwards some stimulating fluid, as a solution of nitrate of silver, iodine, or chlorinated soda, for the purpose of changing the condition of the mucous membrane of the uterus. If any putrid matter is present, it should, of course, be removed.

DROPSY.

Large quantities of water—ten, fifteen, and even twenty quarts—have been known to accumulate in the cavity of the womb, chiefly in young and middle-aged married women. The affection, however, is extremely rare, and is always connected with closure of the mouth of the organ, caused by previous inflammation, malignant disease, or some morbid growth. The fluid is generally clear and limpid like the serum of the blood, which it also resembles in its chemical properties. In some cases it is thick and turbid; it has also been found of the color and consistence of coffee grounds, probably from the admixture of sanguineous matter. The tumor thus formed often simulates pregnancy, is painful on pressure, and slightly fluctuates under the fingers. The disease, technically called *hydrometra*, is occasionally connected with utero-gestation, of which it then forms one of the most distressing complications. Its true pathology is still involved in obscurity. In all probability it is dependent upon chronic inflammation of the lining membrane of the womb, the character of which is changed into a kind of adventitious serous structure.

The affection, which is always slow in its progress, is characterized by the existence of a tumor, of a rounded shape, which, commencing low down in the pelvis, gradually ascends towards the umbilicus, occupying the middle line. It is soft and fluctuating, dull on percussion, of uniform consistence, and unaffected by position. Its identity with the uterus is easily established by vaginal examination, the neck of the organ being effaced, and the part distinctly fluctuating. When the uterus is

not completely occluded, there is occasionally a partial escape of serous fluid. Menstruation is arrested, and the general health, although, perhaps, unaffected in the earlier stages of the disease, always seriously suffers in the end.

The only remedy for this complaint is tapping, the operation being performed at the natural site of the orifice of the uterus, or, if this cannot be found, at the most protuberant part of the swelling. The fluid being evacuated, patency of the opening is maintained by the retention of the canula, or the use of the bougie. If reaccumulation occurs, the fluid is again evacuated, and an attempt should then be made to destroy the secreting surface of the organ by the injection of a small quantity of a weak solution of tincture of iodine. Tapping above the pubes, in this complaint, is objectionable, as it might be productive of fatal peritonitis.

HEMORRHAGE.

Of hemorrhage of the uterus I shall speak only as it affects the organ in the unimpregnated state. The occurrence is most common in married females, about the cessation of the menstrual function, and it is observed in every state of the constitution, in the strong and plethoric, as well as in the feeble and relaxed. A great variety of causes may give rise to it; but by far the most frequent is that peculiar state of the system which accompanies the disappearance of the menses, together with ulceration of the mouth of the womb, or the presence of some adventitious growth. Disease of the ovary also powerfully predisposes to this lesion; and there are some females who are naturally, or from habit, so prone to it that the most trifling exertion is sufficient to bring on an attack. The duration of the hemorrhage varies from a few days to several weeks. When dependent upon structural disease, or the presence of a polypous tumor, the blood often comes away suddenly, in a gush, which continues, at intervals, for a few hours, and then ceases.

The existence of hemorrhage of the uterus, in the unimpregnated state, especially if it be chronic, should always induce a careful exploration of this organ, with a view to the ascertainment of the nature of the exciting cause, which, unless the woman has reached the change of life, will generally be found to depend upon the presence of some tumor, the removal of which promptly arrests the disease.

When the hemorrhage depends upon atony of the uterus, associated with an anemic state of the system, a course of chalybeate tonics, in union with quinine, and the cool shower-bath are indicated. The bowels are properly attended to, and the diet should be nourishing, but non-stimulating. The woman must keep her bed or lounge, as the erect posture never fails to aggravate the complaint. If the flow is at all active, acetate of lead and opium, or perchloride of iron, are employed, ice is applied to the hypogastric region, and strict recumbency is enjoined. If the organ is deficient in proper contractile power, ergot is freely administered. If a good deal of blood has already been lost, prompt recourse is had to the tampon, consisting of a mass of raw cotton or a piece of sponge wet with a strong solution of alum, or, what is much better, of subsulphate of iron, and carefully inserted into the vagina, in contact with the orifice of the womb, retention being aided by a broad compress upon the vulva and a T-bandage. The most unobjectionable plug of all is the colpeurynter, a gutta-percha bag, inserted into the vagina, and distended with air or water. If the ordinary materials are employed, substitution must be effected at least every forty-eight hours. In chronic uterine hemorrhage, a large blister to the sacrolumbar region often proves beneficial.

MYOMATOUS AND FIBRO-MYOMATOUS TUMORS.

Muscular and fibro-muscular tumors of the womb are most common in married, elderly females, and they may occur in its substance, as intramural formations, in its cavity, or on its outer surface beneath its serous covering, as submucous or subserous projections or polyps, or in all these situations either simultaneously or successively, as in fig. 656. Of 74 cases, analyzed by Mr. Thomas Lee, 4 affected the neck of the organ, 22 were seated in the anterior or posterior wall, 18 projected at the exterior and 6 at the interior of the fundus, and 19 extended into its cavity. Their shape is usually spherical; their diameter from the size of a hickory nut to that of a large melon; their weight from a few ounces to upwards of a hundred pounds, as

Fig. 656.



Myomatous Tumors of the Uterus, both Internal and External.

grayish appearance, intermixed with muscular fibres, the color of which is roseaceous, or reddish-white. The older the growth, and the more it has the detached or polypoid form, the more does it lose the characteristics of myoma, and assume

Fig. 657.



Fibro-myomatous Tumor of the Uterus.

in the remarkable case reported by the late Dr. Francis, of New York. Formerly described as fibrous or fibroid tumors, these neoplasms, whether of extramural or intramural origin, contain, as was first pointed out by Vogel, smooth muscular fibres in varying proportions. When the muscular elements predominate, and are disposed in more or less regular parallel bundles, which may be readily separated, while the interstitial connective tissue is soft, loose, sparse, and vascular, imparting to the growth a comparatively soft, elastic consistence, a rather uniform fibrous appearance, and a whitish or reddish-white color, on section, the growth may be considered as a myoma. When, on the other hand, the tumor is rich in thick, dense, indurated connective tissue, and the vessels and muscular fibres are poorly developed, it should be classed, histologically, as a fibro-myoma. On section, such a growth is found to be composed of strong, closely interlacing, irregularly disposed, or concentric fibres, which have a shining white, tendinous, or

grayish appearance, intermixed with muscular fibres, the color of which is roseaceous, or reddish-white. The older the growth, and the more it has the detached or polypoid form, the more does it lose the characteristics of myoma, and assume those of fibro-myoma, the purer forms of myoma being of more recent development and having closer connections with the uterus. The microscopic appearances of the fibro-myomatous tumor are well shown in fig. 657, from Billroth.

These growths are liable to certain degenerations, as the fatty, nœvoid, cystoid, calcareous, sarcomatous, or carcinomatous. The softer varieties, or myomas, are particularly apt to be the seat of nœvoid and cystic changes, the former manifesting itself by great enlargement of its vessels, particularly of its veins, through which its structure is rendered similar to that of the cavernous bodies of the penis, and is endowed with a certain degree of erectility. Under these circumstances the tumor is termed telangiectoid or cavernous myoma. In a tumor of the uterus, observed by Cæsar Hawkins, there was a huge cyst which contained nearly two gallons of fluid. Analogous cases have been reported by

Hewett, Schuh, Lee, Kiwisch, and others, the cystic myoma thus formed being described by some authors as a distinct neoplasm, under the name of fibro-cystic tumor of the uterus. This metamorphosis is not due to the formation of true cysts, lined by a distinct membrane, but to mucoid softening of the interstitial connective tissue, through which spaces or cavities are created in certain portions of the growth, sometimes traversed by bands of tissue, and resembling the cavities of

the heart. In some instances it is possible that they arise from enormously dilated lymph spaces. The younger and smaller spaces are filled with a clear, or straw colored, sero-albuminous fluid, not unlike normal synovia, while the contents of the older and larger varieties are discolored by blood, and vary in tint from bright red to blackish-brown. The calcareous transformation is by no means rare. Most frequent in the subserous fibrous forms of the affection, it usually manifests itself as an infiltration of the connective tissue of the deeper portions of the tumor, or as a complete petrification of the entire mass. In some instances it almost encases these morbid growths, in the form of a thin, brittle shell, not unlike that of an egg. The deposit consists chiefly of phosphate and carbonate of lime, together with a minute quantity of animal matter. A tumor of this kind is occasionally spontaneously expelled. The carcinomatous and sarcomatous degenerations are uncommon.

Only one such tumor may exist in the uterus; or there may be a considerable number, perhaps as many as six, eight, ten, or a dozen. When large they are usually lobulated, or divided by deep fissures. When seated under the serous covering of the uterus, these tumors often hang by a very slender neck, and they then assume a pyriform shape. They possess very little sensibility; and so long as they remain small, they produce no material change in the form of the uterus, or any particular local inconvenience; but, when they attain a large bulk, they not only incommode by their weight, but may cause great displacement of the organ, and, by the pressure which they exert upon the bladder and the rectum, seriously interfere with the expulsion of the urine and feces. When they are imbedded in the walls of the womb, or spring from its inner surface, the subjects of them are commonly barren; or, if they conceive, the uterine tissue is unable to undergo the necessary expansion, and abortion results. More or less copious hemorrhage frequently attends the submucous variety of the myomatous growth, especially when it has an unusually broad attachment. Sometimes a tumor of this kind springs from the base of the womb, whence it ascends into the abdomen, where it may be moved about from side to side, and so simulate pregnancy, or ovarian disease. A case of fibro-calcareous tumor communicating with the bladder has been recorded by Dr. Fleming.

A good idea of the situation, shape, and mode of attachment of the myomatous tumor of the uterus may be formed by a reference to fig. 656, from a preparation in the late Professor Meigs's collection.

The diagnosis of the myomatous growth of the womb is uncertain, except when it occupies the cavity of the organ, and projects down into the vagina, or beyond the vulva, when a careful examination will generally serve at once to reveal its true character. When the tumor is extra-uterine, the proper mode of proceeding is to get, if possible, the body of the womb between the left index-finger in the vagina and the right hand upon the hypogastrium. This may generally be readily accomplished, provided the abdominal muscles be previously thoroughly relaxed and the bladder and bowels well emptied. Sometimes valuable information may be elicited by the finger in the rectum. The intramural tumor may usually be detected in the same manner as the outer. If pressure be made upon it, it invariably moves in unison with the womb, and a sound, probe, or catheter introduced into the cavity of the uterus will be found to pass over a much wider space than naturally; often, indeed, over a distance of many inches both in length and diameter. Whatever may be the original site of the tumor, whether anterior, lateral, or posterior, its tendency generally is, as it ascends into the abdomen, to assume a more or less central position; a circumstance of no little importance in regard to the distinction between such a growth and an enlarged ovary. A myomatous tumor seated within the cavity of the uterus is not easily diagnosed so long as it is small. This is especially the case when it is sessile, or attached by a very broad base. Under such circumstances, in fact, it might easily be mistaken for the gravid uterus. The discrimination is much easier when the adhesion is by a narrow pedicle. In all cases of doubt the most certain plan is to use the sound, or, what is often far preferable, a common medium-sized catheter with a stylet, passed gently into the uterus over the morbid mass. If, in doing this, the instrument, as it is moved about, can be felt by the hand resting upon the hypogastrium through the thin walls of the womb, it may reasonably be assumed that the morbid growth is intra-uterine.

The affections with which the myomatous growth of the uterus is most liable to

be confounded are tumors of the ovaries, the Fallopian tubes, and the pelvic cavity. A careless observer might possibly mistake it for pregnancy, especially when, situated in the direction of the middle line, it is of large size, of rapid development, and of a rounded, convex shape. When the growth is extramural, the neck and mouth of the uterus seldom undergo any material change, but the body is generally, if not invariably, more or less hypertrophied, and, as a necessary consequence, the canal is proportionately increased in length and diameter, the former often amounting to four, five, and even six inches. As no such alterations occur in ovarian disease, they constitute facts of great diagnostic value. When, on the contrary, the growth occupies the cavity of the womb, the canal is either very much contracted, or totally obliterated, and the cervix is also eventually effaced, precisely as in the latter stages of pregnancy. In the mural variety of fibrous tumor there is commonly no morbid uterine discharge—not perhaps even any interruption in the menstrual function—whereas there always is when the tumor occupies the cavity of the organ.

When a myoma of the uterus is of a cystic nature, the distinction between it and an ovarian tumor is very difficult, if not impracticable. The enlargement thus occasioned may be very great, and, if accompanied by fluctuation, as it will be almost sure to be, could scarcely fail to lead to the suspicion of the existence of ovarian dropsy. The safest guide, in such an event, would be the condition of the mouth, neck, and canal of the uterus, which are seldom altered in ovarian disease, but nearly always more or less in myomatous growths of the uterus.

The treatment of myomatous tumors of the uterus is very unsatisfactory. As yet, no internal remedies have been found to be of any material benefit in dispersing them, or arresting their development. I have often tried inunctions with the dilute ointment of biniodide of mercury, and the internal use of iodine in various forms and combinations, iodide of iron, mercury, and hydrochlorate of ammonia, without the slightest effect. When a tumor of this kind is partially detached, its expulsion may sometimes be expedited by the use of ergot. When the growth occupies the cavity of the organ, and has a comparatively narrow pedicle, removal may sometimes be readily effected with the forceps, knife, scissors, ligature, or *écraseur*, as in an ordinary polyp. Even when the growth has a very broad base, portions of it may sometimes be tolerably easily removed in this wise, although in general it will be best, under such circumstances, when interference is indispensable, to attempt relief by enucleation by means of the fingers, scissors, gouge, bistoury, and other instruments, as practised by Atlee, Davis, Grimsdale, Brown, and others. The operation, however, is not without risk, and should, therefore, not be undertaken without due deliberation and care. The immediate danger is hemorrhage; the remote, pyemia. When the intra-uterine tumor is of a cystic character, great relief sometimes follows puncture of the cyst through the vagina.

When the tumor is imbedded in the wall of the viscus, or connected with its outer surface, the case may be regarded as irremediable. An operation, it is true, has now and then been performed under such circumstances, but the result has not been such as, in my judgment, to encourage repetition.

When the growth is situated in the uterine cavity, it is occasionally expelled spontaneously, and the woman either recovers, or dies of the profuse hemorrhage that ensues.

The hemorrhage attendant upon myomatous tumors must be arrested with tampons of subsulphate of iron, or the styptic lotion of Dr. Savage, of London, consisting of one drachm of iodine, with twice that quantity of iodide of potassium, two ounces of rectified spirit of wine, and four ounces of water, carefully injected into the cavity of the uterus, the neck of which is previously well dilated with a sponge tent.

POLYPS.

There are, so far at least as my observation extends, not less than four varieties of uterine polyps, the fibro-myomatous, vascular, mucous, and glandular, of which the first is by far the most common.

This *fibro-myomatous* variety is nothing more than a submucous fibro-myomatous tumor of the womb, which, having originated as a small, round nodule, in the internal layer of its muscular structure, during its further growth, has advanced into its cavity, and become invested with its mucous membrane. Of a fleshy consistence, firm,

yet compressible, smooth, elastic, of a pale grayish color, and composed of dense filaments, which are so intimately interwoven with each other, as to render it impossible to unravel them, this variety of polyp usually springs from the anterior and posterior walls or fundus of the uterus, and is made up of fibro-muscular tissue, although the muscular element may predominate in young growths. When, however, it has attained considerable volume, and when it arises from the neck of the womb, which is rather of a fibrous than of a muscular constitution, it should be classed, histologically, among the fibrous myomas. In its shape it is commonly globular or pyriform. Its pedicle may be thick and muscular, or narrow and fibrous, the muscular tissue disappearing as the tumor increases and becomes more dependent, the size of the pedicle being proportionate with that of the growth. It has few vessels, and is, therefore, little disposed to bleed or to be attended with pain. Tumors of this kind have often a very rough surface, and they sometimes contain considerable cavities filled with mucus, pus, or earthy matter.

The *vascular* polyp is composed essentially of hypertrophied and highly vascular papillæ, the fibrous element being either entirely wanting, or existing only in a very limited degree. This species is extremely rare, occurring only in the neck of the uterus, and seldom attaining a large size; it is of a red, florid color, of a soft, spongy consistence, sensitive on pressure, erectile, and exceedingly prone to hemorrhage. In respect to shape, it presents the same diversities as the other species.

The vesicular, *mucous*, or gelatinoid polyp holds a kind of intermediate rank between the two preceding, being softer than the fibrous and harder than the vascular. It is semitransparent, of a peculiar grayish complexion, compressible, glistening on the surface, and attached by a delicate pedicle, which renders it pendulous. Carefully examined, it is found to exhibit a shreddy, tremulous structure, interspersed with a few vessels, which are generally too small to emit much blood. The mucous polyp may acquire a large bulk, and is influenced by atmospheric vicissitudes, increasing in size when the weather is moist, and diminishing when it is dry.

The *glandular* or adenoid polyp consists in an enlargement of one or more of the mucous follicles, situated in the neck and at the mouth of the womb, which are not only elongated, dilated, and lined by enlarged cylindrical epithelium, but partly converted into cysts. The stroma is made up of succulent fibrous tissue, and sometimes of smooth muscular fibres, containing numerous vessels. Hence, its similarity to certain soft polyps of the nose is very striking. It almost always occurs in clusters, of a reddish, whitish, or grayish color, commonly about the size of currants or small grapes, suspended by long, slender pedicles, and strongly resembling, in their general appearance, the surface of a cauliflower. Occasionally the granular matter bears a striking resemblance to fish-spawn, as in a case recently under my treatment in a married lady, thirty-seven years of age. When there is only one such tumor, it may attain the volume of a walnut, or of a hen's egg. It is invested by a smooth, delicate, vascular membrane, possesses little sensibility, and often contains a yellowish, curdy matter, which is apparently nothing but altered mucus and epithelium. Its connection with the uterus is very slight, and its growth generally very tardy.

Uterine polyps are found of all sizes, from that of a bean up to that of a gourd. Fig. 658 represents a small tumor of this kind, of a pear-like, lobulated form, attached to the base of the cavity of the womb. Their volume, in some cases, is immense, ranging from ten to nearly forty pounds. They occasionally extend far down into the vagina; and cases have been witnessed in which they reached more than ten inches below the vulva, as seen in fig. 659. The shape of these morbid growths is mostly pear-like; and, although they may originate in any portion of the cavity of the uterus, they are most frequently attached to its neck. Many of them have a narrow, slender pedicle; and, in such as are of great size, it is not uncommon to see deep fissures, which give them a lobulated arrangement. They are all invested by a thin mucous membrane, which is more or less vascular, and merely a prolongation of that of the womb, immediately beneath which the morbid growth is developed. Large cavities, filled with various substances, are sometimes seen in them.

Polyps of the uterus are most common in elderly women, especially in such as have borne children. Their progress, which is usually very tardy, is characterized by vague, irregular pains, and by more or less hemorrhage, with a sense of weight and fullness in the pelvic region, vesical trouble, and a thin, sanious, fetid, or leucor-

rhœal discharge. The menstrual function is either entirely arrested or extremely irregular. The diagnosis can only be determined by a careful examination. If the tumor is of considerable bulk, it will be very apt, in time, to protrude at the vulva.

Fig. 658.



Uterine Polyp attached to the Base of the Organ.

Fig. 659.



Uterine Polyp hanging from the Vulva.

Care must be taken not to confound a polyp of the womb with a recto-vaginal hernia, a prolapsed vagina or bladder, or an aborted ovum retained in the neck of the uterus.

The termination of this disease is uncertain. In some cases, the patient lives in comparative comfort for years, while in others life is rapidly worn out by the constant hemorrhages that are so liable to attend it. I have seen nearly half a dozen women perish from this cause. Now and then an instance of spontaneous expulsion occurs, followed by speedy recovery.

The only *treatment* that is of any avail in uterine polyps is removal, and the earlier this is effected the more likely will the woman be to make a good recovery. The operation may be performed by evulsion, ligation, or excision, precisely as in polyps of the nose. When the tumor is comparatively small, with a narrow pedicle, I always give the preference to the first of these methods, as being both safe, easy, and expeditious. The proper instrument is a large lithotomy-forceps, with rough, serrated blades, to insure a firm grasp. Or, instead of this, a Museux's forceps, or stout volsella, may be used. When the tumor is not too large, removal may be effected with the *écraseur*, the most convenient and effective of which is that of Sims, the chain of which, instead of being flexible, as in the ordinary contrivance, is rendered stiff by the addition of a pair of dilating forceps, so that it may be passed into the vagina, and even into the cavity of the uterus, as easily as a probe. The patient, during the operation, lies on the back, or on the left side, with the limbs elevated and well retracted; and care is taken not to cause undue displacement of the organ. The vagina is expanded with the duck-bill speculum.

A very ingenious instrument, called a polyptrite, for the removal of uterine polyps, operating upon the principle of the *écraseur*, has been devised by Dr. Aveling. It consists, as seen in fig. 660, of two branches, one of which is bent at the extremity for seizing the morbid growth, while the other, which slides within the former, is designed to crush it. The strongly serrated forceps of Professor Agnew also serve an excellent purpose.

Ligation may be necessary when the tumor does not yield to evulsion, or when it has an unusually large base. The wire may be applied by means of a long double canula, and should be drawn with great firmness, so as to cause speedy strangulation. Great care is, of course, taken not to include any portion of the uterus.

Occasionally, the object may readily be effected with a stout, well-waxed ligature,

passed around the tumor, and tied with the ingenious instrument of Dr. A. L. Carroll, delineated in fig. 661. The blunt hooks are at a right angle with the blades, which operate upon the principle of a glove-stretcher, and the knots are secured almost with as much ease and rapidity as when the parts are accessible to the fingers.

Fig. 660.



Aveling's Polyptrite.

Fig. 661.



Dr. Carroll's Knot-tier.

Although ligation may occasionally be required, experience has shown that it is often a hazardous procedure, and for this reason is now seldom employed. Of 10 cases collected by Dr. McClintock, of Dublin, 3 died, while of 24 treated with the knife, scissors, or *écraseur*, not one proved fatal. The operation in the hands of Dr. Lee, of London, was almost equally disastrous; for of 59 cases reported by this distinguished accoucheur, there were 9 deaths, two of the women having perished before the removal of the tumor was effected. The same author refers to 35 other cases in which uterine polyps were removed by torsion or excision without one fatal result. When the ligature is employed, the vagina and uterus should be frequently and thoroughly washed out with weak lotions of permanganate of potassa; otherwise, the foul secretions being retained, there will be great danger of pyemia.

Excision is applicable only, or mainly, to small polyps with a narrow pedicle. When the growth is large, there is danger of profuse hemorrhage. The most suitable instrument is a pair of scissors with short, narrow, crooked blades, or a long probe-pointed bistoury, slightly curved towards the extremity, which is carefully insinuated around the neck of the polyp, the womb being previously drawn down with a volsella. Sometimes a small polyp may readily be scraped off with a gouge. The operation, however, requires care; for, if the parenchymatous structure of the womb is injured, fatal inflammation may ensue.

Most of the above procedures will be greatly facilitated by drawing the morbid growth previously down into the vagina, or even beyond the vulva, and separating it from the walls of the uterus by the interposition of sponge tents. Occasionally partial detachment may be brought about by the internal use of ergot, given for a few days before the operation.

Should hemorrhage follow these operations, it may usually be promptly checked by astringents, as powdered alum, or subsulphate of iron, and a full anodyne, with ice to the hypogastrium. If these means fail, or the case is urgent, recourse is had to the tampon.

CARCINOMA.

Carcinoma of the womb presents itself in two varieties of form, the epithelial and the encephaloid, of which the first is by far the more common. A number of diseases, apparently of the most heterogeneous character, but in reality very similar, if not identical, have been described by authors under the several denominations of scirrhus, fungus hematodes, cauliflower excrescences, corroding ulcer, carcinoma, and epithelioma. Scarcely any one of these appellations seems to me to be well chosen, as they have reference rather to certain states or appearances of the parts than to their true nature and constant anatomical characters. Not unfrequently, all the conditions expressed by these terms are blended together, and, even when they exist separately, they have invariably the same distinctive tendency.

Malignant disease, of whatever nature, generally begins at the neck and lips of the organ, from which it gradually ascends to the other parts. So common is this mode of attack that it was once supposed to be invariable. Recent observation, however, has proved that there are numerous exceptions to this rule, the disease in many cases commencing at the base or body of the viscus, and thence spreading downwards towards its inferior extremity.

In *epithelioma*, the mouth of the womb is usually extremely hard, thick, and irregular, the lips being everted, painful on pressure, and apt to bleed on the slightest touch. After some time ulceration takes place, a thin, sanious fluid, abundant in quantity, and highly irritating in quality, oozes from the vagina, and all the textures of the affected part are completely destroyed. The base and body of the uterus, which are often much enlarged, also change their appearance; they become hard and firm, like fibro-cartilage, and are intersected by dense, grayish filaments, running in a radiating direction.

There is a soft, papillary form of epithelioma of the uterus, first accurately described by Dr. John Clarke, of London, under the name of *cauliflower excrescence*, occasionally, although rarely, met with in this country. Its general features are well illustrated in the annexed cut, fig. 662, from Simpson. It is most common after the age of forty, springs invariably from the mouth and neck of the uterus, is rapid in its growth, and is always attended with a profuse watery or sero-sanguinolent discharge, highly fetid and exhausting. The morbid structure is of a soft, fungoid nature, deeply fissured, granulated, of a pale flesh color, very vascular, and prone to bleed on the slightest touch. As the mass increases it dilates the vagina, and sometimes protrudes at the vulva. Death finally occurs, after a period varying from fifteen to eighteen months, from constitutional irritation, or from the effects of putrid and hemorrhagic discharges.

The cauliflower excrescence is of the nature of epithelioma with excessive outgrowth and carcinomatous infiltration of the normal papillæ or villi of the mucous membrane. In this respect it resembles the so-called "villous carcinoma" of other mucous surfaces. In general it is undoubtedly highly malignant, but instances occur where the action is, apparently, altogether of a benign character. In the case from which the engraving, fig. 662, was taken, the patient remained well at the end of eighteen years after the removal of the neck of the uterus. She made a very rapid recovery, and became afterwards the mother of five children.

In the majority of instances of extirpation of the so-called cauliflower excrescence without relapse, it is highly probable that the surgeon has had to deal merely with a simple, exuberant papillary tumor of the mouth of the uterus, a form of disease not unfrequently met with in this situation, and very similar in its general appearance to papillary epithelioma.

The *encephaloid* or glandular carcinoma generally occurs in the body of the uterus, converting its walls into soft masses, which vary in color according to the degree of their vascularity, being at one time uniformly white, at another, of a deep red tint, and in other cases, again, of a dark brownish complexion, caused by inter-

Fig. 662.



Cauliflower Excrecence of the Posterior Lip. *d*, Healthy Anterior Lip. *c*, *e*, Base of Anterior Lip. *d*, *d*, Portion of healthy Vaginal Mucous Membrane Removed along with the Cervix.

stitial hemorrhage from rupture of the enormously enlarged vessels. Their size seldom exceeds that of an orange, but sometimes they are as large as a foetal head, of an irregularly globular figure, filling the pelvic cavity and displacing the neighboring viscera.

As carcinoma of the womb, of whatever form, progresses, various morbid growths spring from the ulcerated surface, and fill up the vagina. These, at length, fall off by sloughing, and are either speedily succeeded by others, or they leave a deep, excavated sore, with hard irregular edges. In this stage of the complaint, there are generally copious discharges from the vagina, consisting of a thin, corroding sanies, serum, pus, or sero-purulent matter, almost insupportably offensive.

Epithelioma of the uterus is most common in married females that have borne children, soon after the decline of the menses. Mr. S. W. Sibley, of London, finds that of 135 women affected with carcinoma of the uterus, 123 had borne children, and 12 had not; making thus a difference of 86 per cent. Very few cases occur before forty and after sixty. Encephaloid, on the contrary, may take place at any period of life. Of 409 cases of carcinoma of this organ, examined by Boivin and Duéges, 95 are stated to have appeared before the thirtieth year, and the probability is that all, or nearly all, of these were examples of brain-like carcinoma.

The *symptoms* of carcinoma of the uterus are usually unequivocal, even at an early period of its existence. One of its very first effects is hemorrhage, not slight, but severe, long continued, and recurring, with more or less frequency, throughout its entire progress, becoming gradually more and more profuse, especially in encephaloid. It is, therefore, a phenomenon of great diagnostic value, particularly in the incipient stages of the affection. The pain is variable. In epithelioma it is usually sharp and lancinating, darting about through the neighboring parts, and coming on at an early period. In soft carcinoma, it is comparatively slight, especially prior to ulceration, after which it is often very severe. The general health seldom suffers much for several months; it then begins to decline, the patient losing her appetite, flesh, and strength, and the countenance ultimately assuming that peculiar, sallow, cadaverous aspect, so characteristic of the carcinomatous cachexia. The discharges are now also very profuse, and generally so excessively fetid as to be almost of themselves denotive of the nature of the malady.

Fig. 663.



Carcinoma of the Neck of the Uterus, ending in the production of Recto-vesico-vaginal Fistula.

As the disease progresses, the morbid action gradually extends to the neighboring organs, as the vagina, rectum, and bladder, the two latter of which, as exhibited in fig. 663, are frequently laid open, thus adding greatly to the suffering. The body of the uterus usually retains its integrity longer than any other portion of the organ. After death, the pelvic viscera are generally found to be more or less matted together, and the pelvic and lumbar lymphatic glands are in a state of enlargement.

The period at which carcinoma of the uterus proves fatal varies. Of 120 cases, reported by Dr. J. C. W. Lever, of London, 107 died at an average of twenty months and a quarter from the invasion of the malady. The shortest duration was three months; the longest five and a half years. Marriage and the previous state of the

health did not appear to have exercised any particular influence upon the progress of the disease.

The *diagnosis* of carcinoma of the uterus is not always so easily determined as might at first sight appear, owing to the fact that the disease is liable to be confounded with other affections, as various kinds of ulcers, fibroid tumors, polyps, and pregnancy. The most important considerations are the history of the case, the occurrence of hemorrhage, the character of the discharges, and the peculiar nature of the pain.

Carcinoma, especially the epithelial form, is seldom observed until after the forty-fifth year, and generally begins at the neck of the organ, from which it gradually extends to the body and fundus. Once fairly begun, the disease is persistently progressive until the patient is worn out by her suffering.

The hemorrhage usually begins soon after the establishment of ulceration, and is nearly always most profuse in the earlier stages of the disease. It is frequently the first symptom that attracts attention, and, if the woman still menstruates, or has only lately ceased to be unwell, is very liable to be mistaken for menorrhagia. The bleeding, whether slight or copious, intermittent or almost constant, is invariably accompanied by clots.

The discharge, prior to ulceration, is mucous or muco-purulent, and free from fetor; subsequently, it is ichorous, sero-sanguinolent, dark, greenish, or brown, more or less profuse, irritating, and highly offensive. In some cases it closely resembles the washings of flesh, and occasionally it is quite red from the admixture of blood. Its quantity, fetor, and acrimony, are greatly increased in the latter stages of the complaint.

The pain in carcinoma of the womb is sharp and lancinating, as if a knife were thrust into the body; occasionally it is dull, heavy, aching, burning, or grinding. It is seated deep in the pelvis, and increases with the disease. In some cases it is most distressing in the loins, rectum, anus, or thighs, in the course of the sciatic nerves; and, under such circumstances, it not unfrequently manifests a neuralgic disposition.

The common ulcer of the uterus is generally superficial, and readily amenable to treatment; it is not attended by hemorrhage, and the discharge, never very profuse, is usually muco-purulent, and free from fetor. The syphilitic sore is recognized by its excavated appearance, by the history of the case, and by the existence of syphilitic disease of the vagina, vulva, and other parts.

A fibroid growth, or polyp, is usually distinguished by its peculiar appearance, by the repeated hemorrhages which so often accompany it, and by the absence of sero-purulent, ichorous, or sero-sanguinolent discharge.

Pregnancy may be diagnosticated from carcinoma by the gradual enlargement of the womb, the absence of hemorrhage and fetid discharge, and by the existence of the morning sickness.

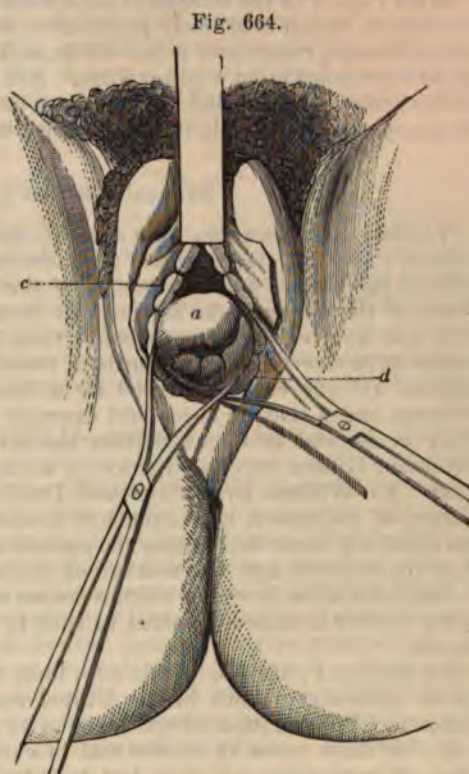
Finally, the diagnosis can, after all, only be clearly established by a thorough exam-

ination with the finger and the speculum. No matter how distinctly the signs may point to the existence of carcinoma, such an exploration should never be omitted. The greatest difficulty is generally experienced when the disease is located in the cavity of the organ: when it attacks the inferior extremity the discrimination is usually sufficiently easy. In the former case it is sometimes necessary to dilate the neck with a sponge tent before a satisfactory conclusion can be reached.

The treatment of carcinoma of the womb is entirely palliative. Excision, it is true, has occasionally been advised, and even some very daring feats of this kind have been performed, always, however, eventuating fatally, either on the spot from shock or hemorrhage, or, at farthest, in a few months from a recurrence of the disease, or, what is more probable, from a want of thorough removal. The whole sum of the treatment with the honest and conscientious practitioner resolves itself into the adoption of measures calculated to assuage pain, arrest bleeding, promote cleanliness, and support strength. Recumbency will generally greatly contribute to comfort. When the morbid mass presents itself in the form of numerous excrescences, portions of it may often be advantageously destroyed with the actual cautery, introduced through a wooden speculum.

Arsenic has long been a favorite remedy in the treatment of carcinoma generally; and Dr. W. L. Atlee, of this city, has great confidence in its internal employment in epithelioma of the uterus, in small doses, long continued, and combined with the local use of a very strong solution of iodine in glycerine. His formula consists of one drachm each of iodine and iodide of potassium dissolved in an equal quantity of glycerine, and applied upon cotton or by means of a brush several times a week to the affected surface. Remarkable improvement has been known to follow this treatment. The excessive pain, in the more confirmed stages of the disease, is best controlled by the hypodermic injection of morphia.

When the disease is strictly limited to the neck of the organ, and there are no contra-indications, as, for instance, the existence of carcinoma in other parts of the body, an operation may at least occasionally prolong life and prevent suffering. It is here more particularly that recourse might advantageously be had to the use of the *écraseur*, as being much more rapid in its work than the ligature, and less liable to be followed by hemorrhage than the knife. The manner of performing the operation may be easily understood by a reference to fig. 664, from Chassaignac.



Amputation of the Neck of the Uterus by means of the Straight *Écraseur*. *a*. Shows the Neck of the Organ dragged down to the Vulva by means of Museux's Forceps. *c, d*. The Chain of the Instrument passed around the part to its Base.

SARCOMA.

The sarcomatous tumor of the uterus, whether occurring as a soft, round-celled infiltration of the mucous membrane, or as a firm, spindle-celled outgrowth of the interstitial connective tissue, either pure, or combined with the soft, œdematous variety of myoma, is very rare. A myomatous or fibro-myomatous polyp does not recur after extirpation; but certain polypoid formations are observed which are characterized by a constant tendency to return. Such growths, which resemble ordinary polyps in their external features, but differ from them in the appearances presented by their cut surfaces, are found on minute examination to consist

principally of closely aggregated spindle cells and fine nuclei imbedded in a dimly granular intercellular substance, thus showing the characteristic features of fasciculated sarcoma.

The sarcomatous, fibro-plastic, or recurring fibroid polyp so closely resembles the ordinary uterine polyp that its distinction without the aid of the microscope is almost impossible. Its presence, however, may be suspected by its more rapid development, its larger volume, its softer consistence, its occurrence at a comparatively early age, its liability to ulceration and repeated hemorrhages, its persistent recurrence after removal, and, possibly, the infection of distant organs during its later stages.

With regard to the treatment little need be said. Unless the growth is thoroughly extirpated, which is scarcely possible on account of its intimate connection with the parent tissues, recurrence is inevitable, and partial operations are always followed by rapid reproduction in a softer form. In a few cases surgical interference has apparently prolonged life; but it should not be undertaken unless the mass is productive of annoyance by its weight, exhausting discharges, or displacement of the womb.

HYSTEROTOMY OR CÆSAREAN SECTION.

Various circumstances may arise to render it necessary to open the womb and extract the child, among which the more important are, deformity of the pelvis, rupture of the uterus and the escape of the child into the abdomen, and the sudden death of the mother from accident or disease. The mortality of the Cæsarean section has been variously estimated; thus, some have placed it at 63 per cent., while others have asserted that upwards of two-thirds of those upon whom it is performed perish. Of 424 cases analyzed by a foreign writer, 210, or nearly one-half, died. Velpeau states that no successful example had occurred in Paris during a period of forty years, and in Great Britain the result has been nearly equally unfortunate. Professor Gibson succeeded twice in saving both mother and child in the same patient. Dr. William Byrd Page and Dr. John Neill, of this city, and Dr. James H. Butler, of Baltimore, have each had a case in which the mother was saved, but not the child, the cause demanding the operation being rupture of the uterus. Dr. Walter F. Atlee, in 1869, lost the mother on the seventh day, but saved the child. Dr. W. F. McClelland, of Iowa, in 1859, reported a case in which both lives were preserved; and a similar instance occurred in 1867 in the practice of Professor W. W. Green, of Maine.

Dr. Robert P. Harris, of this city, finds that the Cæsarean section was performed up to 1872 sixty times in the United States, with a saving of 32 women and 27 children. The duration of the labor in 17 cases varied from a few hours to twenty-four. Of these cases 12 women and 14 children recovered. Of the 17 children thus born, 16 were delivered alive, but 2 died soon after birth. Of the 28 mothers that died, 12 perished from peritonitis, 7 from shock and exhaustion, and 2 from convulsions.

Dr. Fleetwood Churchill has collected the particulars of 28 cases in which the Cæsarean section was performed more than once, with a result of 4 deaths, 3 having occurred after the second operation, and 1 after the third. In 20 of the cases the children perished. In one instance, the operation was performed seven times, in another six times, and in a third five times, upon the same woman, with entire safety in each to the offspring.

When hysterotomy is performed on account of deformity of the pelvis, not the least important part of the operation is the division of the Fallopian tubes, in order to prevent future impregnation. If this had been done in the cases of Gibson, Michaelis, and others, there would have been no necessity for a repetition of the operation.

When hysterotomy is necessary, no time should be lost in performing it; indecision and delay would inevitably be fatal. The bladder having been emptied, and the woman lying on her back with the uterus well supported on each side, an incision is carried through the integument along the linea alba, commencing just above the pubes, and terminating near the umbilicus. The tendinous structure is then cautiously divided down to the peritoneum, which is next severed to the requisite extent with a probe-pointed bistoury. The wall of the uterus being now carefully incised, the exposed membranes are ruptured, either through the vagina, or otherwise, and the child and

placenta extracted. Clearance of the pelvic cavity being effected, and any bleeding vessels secured, the abdominal wound is approximated by the twisted suture and adhesive plaster, and the case treated upon ordinary antiphlogistic principles, large doses of opium being given to control the bowels and prevent peritonitis, and special attention being paid to the temperature of the patient's apartment.

The dangers of this operation are, 1st, shock; 2dly, hemorrhage; 3dly, peritonitis; 4thly, metritis; and, lastly, pyemia. Of 147 fatal cases, analyzed by Dr. Charles West, 33 perished of shock, 13 of hemorrhage, and 56 of inflammation of the peritoneum, or of this membrane and of the uterus. When the patient survives the operation for a few days, she may sink under the effects of pyemia or erysipelas.

In regard to the hemorrhage that follows the Cæsarean section, it may be primitive or secondary—more generally the latter—and does not admit of relief. In some instances it proceeds from the incision being extended into the placenta; an accident which, as it may prove fatal in a few minutes, should always be carefully guarded against. The wound in the uterus is commonly very slow in healing, and has occasionally been found in a gangrenous condition after death.

RUPTURE OF THE UTERUS.

The most common cause of rupture of the womb is the violence of its own contraction during labor, the organ bursting under its inordinate action. It may also be occasioned by external injury, as a fall or blow upon the abdomen, by forcible attempts to turn the child; and by the use of instruments in the hands of ignorant, rash, or careless practitioners. When the viscus gives way under its own expulsive efforts, it may usually be assumed that it has either become softened from inflammatory irritation, or that its walls have become weakened and atrophied by fatty degeneration.

Such an occurrence is nearly always fatal, the patient rapidly sinking from the effects of shock and loss of blood. Unless delivery is speedily accomplished, death occurs within a few hours of the accident. When the child cannot be brought away by the vagina—and an attempt to do this is only, as a general rule, to be thought of when the feet are still in the uterus—not a moment should be lost in performing gastrotomy. The incisions should be carried along the linea alba, in the same cautious manner as in the Cæsarean section, the child extracted, the placenta removed, and the blood carefully cleared away from the cavity of the abdomen. Every effort should, of course, be made to induce prompt uterine contractions, as upon the success of this the safety of the patient will mainly depend. The wound, which can seldom be less than ten inches in length, should be closed with a suitable number of twisted sutures, conveyed through the peritoneum as in ovariectomy, and the after-treatment should be conducted upon general principles. Lambron, in a case of this kind, saved both mother and child.

Gastrotomy is sometimes demanded on account of extra-uterine pregnancy. Unfortunately, however, surgical aid, in such an event, is seldom afforded until it is too late to do any good, the patient usually sinking under the loss of blood before the propriety of the use of the knife is fully determined. Dr. Lloyd Roberts finds that of 32 cases in which gastrotomy was performed for extra-uterine pregnancy, 15 recovered.

Occasionally the child perishes, especially when it has attained maturity, and is ultimately discharged through a neighboring organ, as the large bowel, uterus, vagina, or urinary bladder, through the agency of ulceration. Sometimes, again, the cyst in which the child is contained contracts adhesions to the walls of the abdomen, through which, after long suffering, it at length escapes.

Finally, the child may die, and remain for a long time, if not during the rest of the patient's life, a comparatively harmless tenant in the abdomen, the woman, perhaps, conceiving again, and bringing forth healthy offspring. The fetus, in such an event, is either converted into a fatty substance, not unlike adipocire, or the cyst in which it is enveloped undergoes the fibroid, cartilaginous, calcareous, or osseous transformation.

EXTIRPATION OF THE UTERUS.

The removal of portions of the uterus, or even of the entire uterus, through the vagina, on account of malignant and other diseases, is a procedure which has long been familiar to the profession. Its ablation by the abdominal section, for carcinoma, appears to have been originally proposed by Wrisberg, in 1787, but was first carried into effect by Langenbeck, of Göttingen, early in the present century. The excision of portions of the uterus is a comparatively simple affair, although not always free from danger, whereas the extirpation of the whole organ, whether by the vaginal or abdominal section, is a most hazardous operation. It is, therefore, not surprising that it should generally be condemned, and yet it is easy to conceive that cases may occasionally arise which render its performance perfectly justifiable and proper. Vaginal hysterotomy was first performed in this country in 1830, by Dr. J. Briggs, of Kentucky.

The removal of portions of the uterus may be demanded on account of chronic enlargement, or simple hypertrophy, malignant disease, or inversion of the organ, and may be effected either with the *écraseur*, the knife, or curved scissors. As a preliminary measure, the vagina is dilated with the duck-bill speculum, and the uterus drawn down with a stout volsella. Care is taken to avoid the peritoneum, bladder, and rectum. If an *écraseur* be used, no hemorrhage will be likely to ensue; whereas the bleeding may be very considerable, if not copious, if the operation be performed with the knife, or knife and scissors. However this may be, it may always be easily arrested by means of the hot iron and the cotton tampon wet with a saturated solution of subsulphate of iron. Dr. Sims, who prefers the use of the scissors to the *écraseur*, covers the stump as soon as the bleeding has ceased with the mucous membrane of the vagina, retaining the edges in contact with four wire sutures on each side of the canal of the cervix. In this way the raw surface, instead of healing by granulation, cicatrizes in a few days.

Excision of the neck of the uterus is generally a safe operation. Of 97 cases in the hands of Lisfranc, only 2 proved fatal. Huguier has also been very successful; and of upwards of 50 cases operated upon by Sims, only 1 was lost.

The *écraseur* is now rarely employed for the removal of the neck of the uterus, experience having shown that, while it is not always easy to prevent perforation of the peritoneum, the operation is extremely liable to be followed by undue contraction of the parts.

The after-treatment should be conducted with care. Strict recumbency should be observed for the first week, and the cotton tampon should be removed at the end of the first forty-eight hours, or even sooner, especially in hot weather. The vagina should then be well syringed with a weak solution of permanganate of potassa, and the raw surface dressed with a mixture of glycerine and tannic acid, the process being repeated daily until the parts are completely cicatrized.

Extirpation of the entire uterus by the vaginal section is not only a very difficult but a very dangerous operation. It has hitherto been performed chiefly on account of carcinoma and inversion of the organ, and the result has, in most instances, been promptly fatal. In a case recorded by Dr. James Blundell, of London, the woman, who was fifty years of age, and the subject of carcinoma, was well five months after the operation. The woman operated upon in 1850 by Dr. Paul F. Eve, for a similar affection, died at the end of about three months from a return of the malady. In this instance the entire uterus was removed along with its appendages. A case in which the entire uterus with the left Fallopian tube and left ovary was successfully extirpated by Professor Choppin, on account of proclivita of that organ, in a woman, thirty-eight years of age, is recorded in the *Southern Journal of the Medical Sciences* for February, 1867. The operation was performed partly with the knife and partly with the *écraseur*.

In connection with this variety of the operation, it may be stated that there are at least two well authenticated instances upon record in which the entire uterus along with the ovaries was forcibly pulled away after delivery, under the belief on the part of the midwife that the organ was the placenta, and yet both women made an excellent recovery. One of these cases occurred in Kentucky under the observation of Dr. Ballard, and is circumstantially detailed in the second volume of the *Western Journal of Medicine and Surgery*. The other has been described by Dr. Martin, of Bavaria. A case in which the whole organ sloughed away after a linger-

ing labor, and the woman finally recovered, occurred in the practice of Mr. Darville, of England, in 1839.

This operation is occasionally followed by protrusion of the bowels, but with a little care such an accident is generally easily prevented. The opening in the vagina is speedily filled up by the enlarging bladder, and is finally obliterated by the adhesion of its edges to the surrounding structures.

Extirpation of the uterus by the abdominal section has been strongly advocated by Dr. H. R. Storer, of Boston, who has collected the statistics of 24 cases of the operation by different surgeons, of which 18 died and 6 recovered, affording thus a ratio of mortality of one in five and a half. The diseases necessitating the operation were various non-malignant tumors, as the fibroid, fibro-cystic, and fibro-calcareous, having their origin either in the walls or in the cavity of the organ. The growth in his own case—a successful one—was of a fibro-cystic character, and weighed thirty-seven pounds. The first operation of the kind was performed in 1843 by Mr. Clay, of Manchester; but the first successful result was obtained by Dr. Burnham, of Lowell, in 1853.

The section is generally made along the middle line, between the pubes and umbilicus, as in ovariectomy, and varies, on an average, from five to six inches. The neck of the uterus, if sound, is left behind. Division of the parts is effected with the knife and *écraseur*. The vessels are secured by acupressure and metallic ligatures. The wound is closed with pins or wire sutures passed through the peritoneum. The system should be well prepared for the operation, the bowels and bladder thoroughly evacuated, and the after-treatment conducted upon general principles. The temperature of the patient's apartment should range from 68° to 72° of Fahrenheit. Dr. Storer, in the case referred to, made his incision along the right rectus muscle, a situation which he prefers to the middle line, as the wound, in his opinion, is more likely to heal by the first intention.

The principal sources of danger after this and the vaginal operation are, shock, hemorrhage, peritonitis, and pelvic cellulitis. Of the 18 unsuccessful cases by the abdominal section, collected by Dr. Storer, 6 died of exhaustion, 5 of loss of blood, 6 of inflammation, and 1 of injury received in an accidental fall upon the floor. Since these statistics were published, Dr. Storer has collected seven other cases, all of which, save one, were fatal.

SECT. II.—AFFECTIONS OF THE OVARY.

The most important diseases of the ovary, surgically considered, are inflammation and various kinds of tumors, both of an innocent and malignant character.

INFLAMMATION.

Inflammation of this organ, technically called *ovaritis*, is probably a much more common disease than is generally imagined. It is most liable to occur after difficult parturition, provoked abortion, and suppression of the catamenia, in consequence of cold. In lying-in females it is generally complicated with inflammation of the uterus, Fallopian tubes, and pelvic veins, and, in all cases, it is very apt to extend to the peritoneum.

The symptoms of *ovaritis* are usually extremely obscure, a circumstance which readily accounts for the fact that the disease is so often overlooked. In general, the existence of the lesion may be inferred when there is excessive pain in the pelvic cavity, deep-seated, circumscribed, of a burning nature, and aggravated by pressure, motion, and the erect posture. As the inflammation spreads, the pain and tenderness become more diffused, and the patient generally lies with the limbs well retracted, to take off the tension from the abdominal muscles. High fever is always present; and, if the finger is introduced into the rectum, the ovary may often readily be detected by its large and globular feel.

When the disease passes into suppuration, the occurrence is denoted by rigors, alternating with flushes of heat, and accompanied by throbbing pains and an increased sense of weight in the pelvic cavity. If the quantity of pus be considerable, its existence may generally be discovered by a digital exploration of the lower bowel. The abscess may burst into the peritoneal cavity, causing fatal inflammation; or it may send its contents into the rectum, vagina, or bladder. Occasionally, again,

especially when the inflammation is associated with disease of the uterus and Fallopian tubes, the abscess points in the groin, or in the ileo-inguinal region.

Large accumulations of pus, or sero-purulent fluid, occasionally form in chronic disease of the ovary. In a case of this kind, reported by Dr. Taylor, of this city, the quantity amounted to four gallons. The disease was of long standing, and the organ was converted into a large, vascular sac, weighing seventeen pounds after the removal of its contents.

In the treatment of ovaritis, the principal remedies, in its earlier stages, are, venesection, especially when there is marked plethora, leeches to the hypogastrium and perineum, followed by fomentations, light diet, strict recumbency, and the use of aconite and morphia, with the neutral mixture. When there is much tenderness of the abdomen, a large blister should be applied. The lower bowel is maintained in an empty condition by enemata, but purgatives should be proscribed, as calculated to aggravate the disease. In ovaritis, consequent upon the puerperal state, the vagina should be frequently washed out with demulcent injections, medicated with chlorinated soda or permanganate of potassa.

If matter be detected, it may be evacuated through the posterior wall of the vagina, by means of a long, curved trocar, the canula of which may be retained for a few days, to insure patency of the puncture. If pointing occur in the groin or iliac region, the opening is, of course, made there, but not until there is reason to believe that the sac of the abscess has formed firm adhesions to the surrounding structures. In chronic abscess, the matter sometimes escapes spontaneously by the vagina, or through an aperture in the wall of the abdomen. Should artificial evacuation be demanded, it may easily be effected by a puncture through the linea alba.

DISPLACEMENTS.

Displacements of the ovary are of two kinds, the internal and external, or those in which this organ remains within the pelvis, and those in which it escapes from it so as to form a veritable hernia. The former of these changes are generally dependent upon alterations experienced by the uterus, upon diseased conditions of the ovary itself, or, finally, upon the presence of various kinds of morbid growths, by which the ovary is compressed and forced out of its natural relations. A tumor of the ovary, originally developed in the pelvis, will, if unrestrained, rise out of this cavity, and ultimately, at least in many cases, ascend to a great height in the abdomen. Many of these displacements are irremediable; others admit of relief by rectifying the malformation of the associated organ, as in retroversion and anteversion of the uterus, and others, again, require formidable surgical interference.

The external displacements of this organ are of great interest, both in a diagnostic and practical point of view. The most common of all are those in which the ovary passes out at the inguinal ring, in the ordinary situation of a hernia of the groin. The descent here may be single, or double, as in the celebrated case of Mr. Pott, and is often congenital, or, if not congenital, it arises within a short time after birth. The organ, which may be healthy, or diseased, is sometimes displaced by itself, but more generally it escapes along with the uterus, or the Fallopian tube, or both. Now and then, it is accompanied by a portion of intestine, which is then placed in front, and which always materially augments the bulk of the tumor. Cruveilhier has reported a case in which the ovary was lodged in one of the labia, so as to bear a strong resemblance to a testicle in the scrotum. Examples of its escape at the umbilicus, the femoral ring, and the sciatic notch, have been recorded by different observers, and are referred to by Deneux in his "Memoir on Displacements of the Ovary." Finally, an instance is mentioned by Ruysch in which the ovary passed through an opening into an abscess of the wall of the abdomen.

The diagnosis of a hernia of the ovary is generally extremely difficult. The affections with which it is most liable to be confounded, when it takes place at the groin or the upper part of the thigh, are various morbid growths, as enlarged lymphatic glands, intestinal hernia, and cystic tumors. The situation of the ovary alone will usually suffice to distinguish the disease from a swelling of a lymphatic gland, as the former is nearer to the middle line than the latter. Besides, it is seldom, in the latter affection, that the disorder is confined to one of these bodies; on the contrary, considerable numbers are commonly involved, and they are, moreover, almost invariably more or less tender, red, and inflamed. The ovary always lies at one of the

rings, immediately beneath the skin, forming a firm, movable, clearly defined swelling, free from pain, and unaccompanied by any change of color on the surface. Dragging sensations are experienced in the groin, pelvis, and hypogastrium, increased by walking and other exertion; and the tumor, as already stated, feels hard and solid, not soft and gaseous, as in hernia. The size of the tumor may be considerable when the descent is accompanied by the uterus, or a portion of bowel; and in the latter event the mass may be partly soft and partly solid, very much as in an entero-epiplocele, as was first pointed out by Lassus. When there is any doubt, valuable information may be elicited by the shock impressed upon the tumor through the uterus by the finger in the vagina or rectum. The history of the case must also be carefully considered.

The *treatment* consists in restoring the dislocated organ, if possible, to its natural situation, and in preventing a recurrence of the accident by the use of a truss. Strangulation may require the use of the knife. Lassus, in a case of this kind, left the ovary in its abnormal position in the hope that it might act as a permanent obturator, and a similar plan was adopted by Deneux. Excision may become necessary when the organ is so exquisitely tender and painful as to interfere seriously with comfort and usefulness, as in the case of Mr. Pott, in which both glands were in this condition. A ligature being applied to each pedicle, severance was effected with the knife, followed by speedy convalescence.

TUMORS.

The principal innocent growths of this organ are the fibrous and cystic, the latter of which may be either single or multilocular. Of the malignant, by far the most common is the encephaloid; the colloid, melanotic, and scirrhus being very infrequent.

The purely fibroid tumor of the ovary is uncommon; in most cases it occurs in association with more or less cartilaginous matter and osseous concretions. Its density is, consequently, very great, so much so, as to bear a close resemblance to a mass of scirrhus, thus sometimes deceiving the unwary in regard to its real character. Occasionally cysts of considerable size, filled with various kinds of materials, are interspersed through its substance. In cases of long standing, the fibrous tissue is sometimes almost entirely replaced by the cartilaginous and osseous. The tumor is of a whitish, grayish, or drab color, irregularly lobulated, of slow growth, free from pain, or nearly so, and capable of attaining a large bulk, often weighing many pounds, and greatly incommoding by its pressure.

The *unilocular cyst*, or the simple cystic tumor of the ovary, is, as the name implies, a single bag, consisting essentially of the peritoneal and albugineous tunics of the organ, greatly thickened by interstitial deposits, and occupied by serous fluid, of a pale straw color, viscid in its consistence, and composed of a large proportion of albumen, as is shown by the fact that it is nearly all converted into a solid mass on the application of heat. Its quantity varies in different cases, and under different circumstances, from a few ounces to a number of gallons, as many as thirteen having been removed at a single operation. When the disease is of long standing, the fluid is often remarkably changed in its physical properties. Thus, it may be thick and ropy, like soft soap; green and tremulous, like jelly; or dark and thick, like molasses. The cyst is, at first, very thin, and, perhaps, almost translucent; but, as the disease progresses, it steadily augments in thickness and strength, and eventually acquires almost a leathery firmness. Under these circumstances, also, it generally forms adhesions to the surrounding parts, especially the walls of the abdomen, the bladder, uterus, omentum, and small intestine. Vessels of considerable size may be seen passing over its surface and dipping into its substance.

Of the causes of ovarian dropsy, properly so called, nothing is known; it is often, it is true, ascribed to external injury, as a blow, fall, or kick upon the abdomen, or violence sustained during parturition, but whether it is really ever produced in this way admits of doubt.

Although hardly any period of life, after puberty, is perhaps entirely exempt from this disease, experience has shown that it is most common between the twenty-fifth and fortieth years, or the period of the greatest activity of the sexual organs.

The annexed cut, fig. 665, represents a unilocular ovarian cyst of large size, from a preparation in my cabinet. The uterus is seen to retain its natural form and vol-

Fig. 665.



Unilocular Ovarian Cyst.

ume. Attached to its left horn, at the origin of the Fallopian tube, is a small, globular cyst, adherent by a short, slender pedicle, and entirely unconnected with the ovary on that side.

The *multilocular tumor*, or compound cystic growth of the ovary, fig. 666, is composed of a congeries of cavities closely connected together, or developed, as it were, within each other, of variable size and shape; some being small, and others large, some round, and others ovoidal, or more or less irregular, and most of them occupied by different substances. The youngest generally contain a thin, serous fluid, whereas the older are filled with a thick, glutinous material, resembling

jelly, soft soap, suet, honey, molasses, or a mixture of blood and starch. The larger cysts are often as big as an adult's head, and the walls are then frequently from three to six lines in thickness, very strong, and remarkably vascular. The multilocular tumor is usually of rapid development, and is capable of acquiring an enormous bulk, becoming early united to the surrounding parts, and seriously implicating the

Fig. 666.



Section of a Multilocular Ovarian Tumor.

general health. Cases, however, occur in which its progress, at least for a time, is quite slow. Thus, in a middle-aged woman who was under my charge last summer, the disease was of nearly twenty years' duration. The adjoining sketch shows the secondary cysts on the walls of the largest primary cysts with broken down partitions.

The two forms of cysts here briefly described, which depend essentially, there is good reason for believing, upon cystoid degeneration of the Graafian follicles and the stroma of the ovary, are sometimes associated; one part of the tumor being unilocular, the other multilocular. Again, instances occur in which they contain, as already intimated, various kinds of solid matter, as papillary, adenoid, cartilaginous, and osseous formations. Sometimes they are occupied by hydatids, or acephalocysts, either attached to the inner surface of the sac by narrow, slender necks, or floating about in serum. An ovarian tumor occasionally contains teeth, hairs, and fetal bones,

either in separate cysts, or enveloped in a peculiar, saponaceous, fatty, or suety substance. These dermoid cysts, as they are termed, are nothing more than enlarged Graafian follicles, the walls of which have the structure and properties of the outer skin, and are endowed with great formative power. They sometimes attain the volume of a fœtal head, are observed in intra-uterine and early extra-uterine life, and should not be regarded as rudimentary fœtuses. Finally, cystic ovarian growths, whether simple or compound, are liable to take on inflammation, eventuating occasionally in suppuration, or in the formation of abscesses.

Malignant growths of the ovary are very rare. The most common is the encephaloid; the scirrhus, colloid, and melanotic being, as already stated, extremely infrequent.

Encephaloid may occur at any period of life, in girls, as well as in married women, and usually runs its course with frightful rapidity. The brain-like matter, which distinguishes this disease, is generally found in small, irregular masses, inclosed in distinct cysts, of a fibrous texture. They are usually of different shades of color, being of a pale olive, brownish, or mahogany in some places, white, cream-like, or grayish in others. Branches of vessels may often be traced, in great numbers, into their structure; and not unfrequently they contain large cysts, filled with serum, pus, or sanious fluid.

Scirrhus may occur by itself, forming a hard, dense mass as large as a fist or even a child's head, of an irregular globular shape, of a whitish, grayish, or drab-colored aspect, and intersected by a great number of membranous filaments. The disease is most liable to show itself about the decline of the menses, and occasionally coexists with other morbid growths.

Colloid of the ovary, fig. 667, may occur alone, or it may coexist with other morbid products, particularly the fibrous and encephaloid; it is capable of attaining a large bulk, and exhibits the same structure as in other parts of the body. It is, however, doubtful whether the majority of so-called carcinomas are not really examples of colloid degeneration of the fibrous tissue of the ovary without any malignant tendency.

Melanosis of this organ is not only extremely rare, but probably never occurs without similar disease in other organs. It is most common as an accompaniment of encephaloid, in middle-aged and elderly subjects.

Ovarian dropsy and tumors of large size and of long standing are generally attended with remarkable changes in the walls of the abdomen. The muscles, from the great and constant pressure exerted upon them, are gradually attenuated, and ultimately almost completely deprived of their characteristic features. In a case under my care, not long ago, in an elderly lady who had suffered from enormous ovarian distention for upwards of thirty-five years, the abdominal muscles were reduced to mere fibrous membranes, perfectly white, and without any trace, apparently, of the natural structure. The diaphragm had undergone a similar transformation. When, on the contrary, the disease is of rapid formation, these parts experience no material alteration, and the abdomen may even be unusually loaded with fat.

The internal adhesions vary in degree and extent. In recent cases, the tumor is not unfrequently entirely free, whereas, in old ones, strong and extensive attachments may generally be looked for, not only to the walls of the abdomen, but also to the viscera, especially the bowels and omentum, the latter of which may at the same time be remarkably hypertrophied and vascular.

Finally, ovarian dropsy and tumors may be complicated with, or give rise to, various other affections, as hernia, especially of the umbilicus, hemorrhoids, and prolapse of the rectum, vagina, uterus, and even the bladder, as in a remarkable case under my charge a few years ago. Such occurrences, which are most liable to take

Fig. 667.



Section of a Colloid Tumor of the Ovary.

place when the morbid growth is solid, or partly solid and partly fluid, and firmly adherent to the pelvic viscera, always add greatly to the patient's suffering. In the case just adverted to, the woman was so uncomfortable that she was hardly able to walk or sit, and was constantly annoyed with a desire to pass her water.

Diagnosis.—Tumors of the ovary, from whatever cause arising, are liable to be confounded with various other affections, of which the principal are ascites, tumors of the uterus, pregnancy, and enlargement of the omentum, liver, spleen, and kidney. The greatest difficulty usually occurs when the morbid growth is of a solid nature.

From *ascites*, cystic tumors of the ovary are usually distinguishable by the following signs: 1. They are more tense, circumscribed, and protuberant. 2. They are situated more to one side, especially in the earlier stages of their progress, whereas in general dropsy the distention is equally diffused. 3. They are but little, if any, influenced by change of posture, while in ascites the fluid gravitates towards the lowest part of the abdomen when the patient sits up, and towards the posterior part when she lies down. 4. In ovarian dropsy the neck of the uterus is usually drawn up into the pelvis, perhaps almost beyond the reach of the finger; in peritoneal effusion, on the contrary, it occupies its accustomed situation, and may generally be easily pushed from one side to the other.

Important information is usually furnished by the state of the general health in the two affections. In ovarian dropsy, especially the unilocular variety, the health nearly always remains natural, or nearly so, for a long time; whereas in ascites it is commonly more or less seriously disturbed from the first, the disease which causes and accompanies it having firmly impressed itself upon the constitution before the effusion shows itself. To these circumstances it may be added that ovarian dropsy is usually very tardy in its progress, while ascites is ordinarily quite the reverse.

Fig. 668.



Unilocular Ovarian Cyst, uncovered.

When the disease is complicated with abdominal dropsy, the diagnosis may generally be promptly established by paracentesis. The ordinary situation of the cystic tumor of the ovary is well shown in fig. 668, the wall of the abdomen having been cut away.

Finally, valuable assistance may commonly be elicited by a microscopic inspection of the fluid after tapping. If the tumor be ovarian, there will always be, especially in old cases, an abundance of disintegrated blood globules, large granules, epithelial cells, oil cells, pigments, and crystals of cholesterine, as exhibited in fig. 669. In ordinary ascites, on the contrary, there is generally an absence of these bodies.

Fig. 669.



Microscopical Characters of the Fluid of an Ovarian Tumor.

Tumors of the *uterus* may be mistaken for ovarian, and conversely, as is proved by the fact that a number of operations have been undertaken for morbid growths that were supposed to be ovarian, but turned out to be uterine. The diagnosis between the diseases of these two organs

is by no means always easy. The enlargement of the uterus may depend upon a solid tumor in its cavity, within its walls, or upon its outer surface, and the consequence may be that the organ is pushed to one side, thereby closely imitating the situation of an ovarian tumor, especially in its earlier stages, and rendering it quite impossible to discriminate between them. As the affection of the uterus advances, however, the effacement of the neck of the organ generally affords unmistakable evidence of the fact that the disease is not ovarian. In cases of doubt, the fundus of the uterus, if free from disease, may often be distinctly felt above the pubes, upon the introduction of the sound. A fluctuating tumor of the uterus is sometimes formed by the retention of the menstrual fluid; but its median situation, its globular figure, the absence of the catamenia, and the obliteration of the mouth of the organ, will afford a sufficient guarantee against any errors of diagnosis. Similar changes occur in dropsy of the uterus and in cystic myomatous tumors; while in physometra, or gaseous accumulations, the remarkable resonance accompanying the disease is always characteristic. Finally, in ovarian disease, the uterus generally retains its natural shape and size.

Pregnancy has been mistaken for ovarian disease; such an accident, however, can hardly happen to a cautious, educated surgeon. The chief signs of distinction are, the history of the case, as the morning sickness and the absence of menstruation; the median situation and gradual development of the tumor; the changes in the breast and in the mouth and neck of the uterus; and, by and by, the discovery of the pulsations of the fetal heart and of the placenta.

A sarcomatous enlargement of the *omentum* has been mistaken for an ovarian tumor. The patient, about to be operated upon, has suddenly died, and the dissection has revealed remarkable disease of the omentum, but none whatever of the ovary.

An enlarged *liver*, or spleen, or morbid formations connected with these organs, have occasionally led to errors of diagnosis, and several instances have been reported where, under such circumstances, the abdomen was laid open under the conviction that the morbid growth was a diseased ovary. The elevated and lateral situation of the tumor; its gradual development from above downwards, instead of from below upwards, as in ovarian disease; the continuance of the menstrual function; and the natural position of the neck of the uterus, will generally suffice to prevent mistake. The history of the case will also serve to throw important light upon the diagnosis; for in organic maladies of the liver and spleen, there are always symptoms peculiar to the affections of each of these organs, and which, consequently, are wanting in ovarian tumors.

A renal cyst, hydronephrosis, or dropsy of the *kidney* has been mistaken for ovarian dropsy, as in the remarkably case of a woman, forty-three years of age, operated upon by Mr. T. Spencer Wells. A little care, however, will generally suffice for a correct diagnosis. In renal disease, the tumor is developed from above downwards, is confined originally to the ilio-lumbar region, and only after a long time descends into the pelvis. The growth is fixed in its position from first to last, and there is always, as was first stated by Mr. Wells, a narrow cord-like bridle of intestine, movable on manipulation, in front of the cyst. In renal disease the menstrual function remains natural, and the urine contains an undue quantity of mucus and epithelium, either alone, or, if the ureter is still pervious, mixed with pus or albumen. The exploring needle and the microscope should be employed in case of doubt.

Finally, inordinate distention of the abdomen from the accumulation of gas and *fecal matter* has occasionally been mistaken for ovarian enlargement. Any doubt, however, arising from such an occurrence, may readily be dispelled by an efficient cathartic.

The diagnosis of an ovarian tumor is sometimes rendered difficult by the existence of *air* in its interior, either generated by the partial decomposition of its contents, or introduced through an opening of communication between the sac and the uterus, vagina, or intestinal tube. However this may be, the abdomen always yields a hollow, tympanitic sound on percussion. The most reliable circumstances here, as it respects the diagnosis, are the history of the case, and the inequality in the consistence of the morbid mass, some portions being soft and sonorous, while others are hard and dull.

The diagnosis between *ovarian growths* themselves is not always so easy as might

at first sight appear. The multilocular cyst is usually distinguishable from the unilocular by the greater rapidity of its growth; its more solid character, one part feeling hard and another soft; by a sense of greater weight and pressure; by the more early failure of the general health; and by the more marked enlargement of the subcutaneous veins of the abdomen.

The fibrous, cartilaginous, and other solid non-malignant tumors may generally be readily distinguished, at least in their early career, by their lateral situation, by their great firmness and mobility, by the tardiness of their progress, and by the want of disturbance of the general health, which frequently remains unaffected for years. Malignant ovarian tumors, on the other hand, are characterized by the rapidity of their progress, by their great bulk, by the severity of the local suffering, and by the inroads which they always make upon the constitution even at a very early period of their existence. In encephaloid growths the surface of the abdomen is generally knobby, or very irregular, being hard and firm at one point, doughy and semisolid at another, and, perhaps, elastic and fluctuating at a third. The disease, in its latter stages, is always accompanied by great enlargement of the subcutaneous veins.

The presence of *adhesions* between the tumor and the surrounding parts may generally be inferred by the want of mobility of the morbid mass, as determined by the variation of the patient's posture, a careful digital examination, and the effects of a full inspiration, during which, if the tumor be non-adherent, it is sensibly depressed by the descent of the diaphragm.

Progress.—The progress of ovarian tumors is extremely variable. In the benign forms, it is often remarkably slow, causing hardly any suffering, either local or constitutional. Hence, the patient often lives in comparative comfort for years together, and may even bear children, although, in general, abortion takes place if pregnancy occurs, owing to the inability of the uterus to expand, so as to accommodate itself to the gradual growth of the child. In most cases, however, she suffers great inconvenience and annoyance, and ultimately dies, within the first five or ten years, exhausted, either from the drain upon her system, or from constitutional irritation. The multilocular tumor is always a more serious disease than the unilocular, or fibrous; while the encephaloid pursues a most rapid and unrelenting course, death usually occurring within from ten to fifteen months from the invasion of the malady.

In the simple cystic tumor, the sac is sometimes ruptured, either spontaneously or accidentally; occasionally followed by a radical cure, especially when the tumor is small, but very frequently also by death. Thus, of 72 cases of this kind collected by Mr. Tilt, 32, or nearly one-half, perished from peritonitis.

When a spontaneous cure is effected, the water escapes through the Fallopian tube, vagina, bowel, bladder, umbilicus, or wall of the abdomen. In a case mentioned to me by the late Dr. William Pepper, an enormous ovarian tumor, of many years' standing, emptied itself through the bladder. The lady, feeling a desire to relieve herself, filled in rapid succession six large chamber pots with fluid; the swelling immediately subsided, and a cure gradually followed. In another case reported to me by Dr. T. P. Gibbons, the water apparently escaped through the Fallopian tube. The woman, who was fifty-two years old, woke up suddenly one night, and found, to her surprise, her bed completely deluged with fluid. The tumor gradually decreased, but subsequently refilled, until it had attained a greater bulk than before. At the end of about twelve months, however, it again gave way, and the discharge now continued until all trace of the disease had disappeared. I have the notes of two cases in which the tumor emptied itself through the walls of the abdomen, the cure in one being permanent.

In a case of this disease, in a young lady of twenty-four, whom I saw with Dr. Joseph H. Wythes, the tumor had formed a communication between the fundus of the bladder and the descending colon, eventuating in the establishment of a stercoraceous fistule. After much suffering and annoyance, the opening in the abdomen finally closed, but death occurred three months subsequently from an attack of typhoid fever. On dissection, the ovarian cyst, of an oval shape, and about five inches in diameter, was found to be occupied by a large mass of sebaceous matter, intermixed with a considerable quantity of hair and two irregular pieces of bone, studded with well-formed teeth.

A case in which a fibroid tumor of the ovary, of a spherical shape, and about six inches in diameter, occasioned fatal peritonitis by the twisting of its pedicle, has been reported by Professor Van Buren, of New York.

When ovarian disease coexists with pregnancy, the woman may go to the full term and be safely delivered, provided the tumor is not very bulky or the cyst unusually thin. When this is the case, there is, as Mr. T. Spencer Wells has conclusively shown, great danger of abortion; or, if the full term be reached, of a painful and protracted labor with a dead child; or, what is still worse, the cyst may burst and the mother perish from shock, hemorrhage, or peritonitis. Death, however, even in such an event, is not inevitable. If the tumor be at once removed, and the abdominal cavity thoroughly cleansed, gestation may proceed safely to the full term. Mr. Wells refers to three cases in which the uterus was punctured during ovariectomy, in only one of which recovery took place, owing, as was supposed, to the fact that delivery was effected before the completion of the operation.

Treatment.—Medical treatment exerts little, if any, direct influence upon the progress and termination of ovarian disease of any kind. A cure, it is true, is occasionally effected in unilocular dropsy of this organ, but the occurrence is so extremely infrequent that it must be regarded as altogether of an exceptional character.

The remedies upon which the greatest reliance has hitherto been placed are the different preparations of iodine, as Lugol's solution and iodide of potassium, given in moderate doses, three times daily, and the ointment of iodide of lead, and the dilute tincture of iodine, applied freely to the tumid abdomen, at least twice in the four-and-twenty hours. Pressure has also been highly recommended, but, although I have frequently tried it, I do not know that it has ever afforded any good in my hands, and the same remark, in fact, is true of everything else that I have ever used in the way of general and local medication. Mercury, carried to gentle and persistent ptyalism, has been employed in numerous instances without any benefit.

The treatment, so far as surgical interference is concerned, may be divided into palliative and radical; the former consisting of occasional tapping, to take off the weight and pressure of the fluid from the diaphragm and abdominal viscera; and the latter in the removal of the tumor, or, if it be encysted, in the injection of certain fluids, or the excision of a portion of its walls, with a view to the obliteration of its cavity.

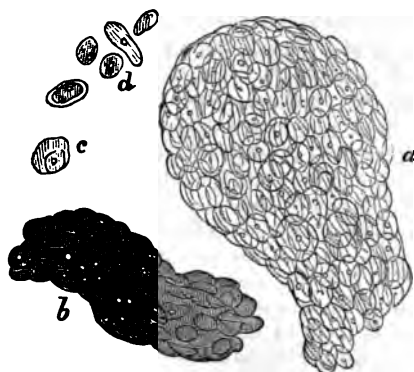
Tapping.—Tapping of the unilocular form of ovarian dropsy is frequently required with a view to palliation; but it should not, as a general rule, be performed so long as the patient is comparatively comfortable, experience having shown that when it has once been done it will usually have to be done soon again. I am acquainted with an instance, in which the cyst, however, is combined with a solid tumor, where the operation has been performed upwards of sixty times in less than a year, the quantity of fluid removed at each operation being from four to eight quarts. The patient usually gets on best after tapping when the cyst is perfectly simple, or when it is associated with a stationary fibrous tumor of small size.

In a case upon which I operated for the late Professor Meigs, in October, 1856, paracentesis had been performed twenty-seven years previously, and yet the general health had all along been very good. Twelve months after this the patient desired to be again tapped, but this I declined doing, and she bore her burden until the spring of 1860. The operation was repeated in May, 1862, thrice in 1863, and once in March, 1864. She died, completely exhausted, the following April, at the age of seventy-one. The quantity of fluid drawn off during this time was sixty-nine gallons, generally of a dark color, highly coagulable, and of the temperature of 98°. The sac, which was unilocular and extremely thin, with a very narrow pedicle, contained five gallons of fluid after death. The only inconvenience that this lady experienced during the seven years and a half of my attendance upon her was of a mechanical character, growing out of the immense size of the abdomen interfering with exercise, good looks, and, at times, with respiration. Her general health was usually most excellent. Altogether she lived upwards of thirty-four years from the time of the first operation.

One of the most interesting features in this case was the existence of thousands of little buds or papillary vegetations upon the inner surface of the sac, resembling very much the granulations of a healing ulcer of the skin. They were of a rounded or ovoidal figure, extremely vascular, and of a beautiful florid color. In size they varied from a clover seed to that of a large pin head. The microscopical appearances of these vegetations are well illustrated in fig. 670, from a drawing by Dr. Packard.

In general, the water rapidly reaccumulates after tapping, despite everything that can be done to prevent it. In most of the cases in which I have performed it, the

Fig. 670.



Granulations of an Ovarian Cyst. *a*. Papillary Process of one of these Bodies. *b*. Part of a Papilla undergoing Fatty Degeneration, the Nuclei and Cells becoming indistinct. *c*. A Detached Cell. *d*. Detached Nuclei.

tumor was nearly as large in three or four weeks, and sometimes even at the end of a fortnight, as at the time of the operation. In consequence of the steady drain thus established, the patient generally rapidly declines in flesh and strength, and ere long dies completely exhausted.

Now and then, as happened in my own case, the patient lives many years in comparative comfort after such interference. Nockler, father and son, tapped a female, in thirty-one years, 122 times, from sixteen to eighteen quarts of fluid being drawn off at each operation. She was in good health at the age of sixty-nine. A still more remarkable instance has been recorded by Roloff, in which a woman, forty-four years old, was tapped altogether, during seven years, 187 times, 125 times by her medical attendant, and 62 times by herself. The operation was, at first, performed very seldom, but latterly every third day. In the

celebrated case of Martineau paracentesis was performed eighty times in twenty-five years, the entire quantity of water drawn off being, in round numbers, 829 gallons. Sir Astley Cooper has recorded the case of a woman who died in her twenty-third year, after having been tapped in less than four years 155 times. Temporary relief occasionally follows paracentesis in the multilocular variety of ovarian dropsy, even when the quantity of fluid removed is comparatively small.

The best point for performing the operation is the site of ordinary paracentesis; the patient is placed in a similar posture, with the same precaution as to the support of the abdomen, and a very suitable instrument is a common large, round trocar six inches in length; or, instead of this, the trocar of Mears or Wells may be employed, the fluid flowing through a gum-elastic tube into the receiver. When the tumor occupies the side of the abdomen, care must be taken to puncture it external to the course of the epigastric artery, otherwise this vessel might be wounded, and the patient die of hemorrhage. The operation may sometimes be advantageously performed at the umbilicus, which, when the tumor is large, and of long standing, often presents a pouting appearance, in consequence of the separation of the straight muscles. In a case under my observation not long ago, the patient, a very respectable lady, was in the habit of tapping herself here with an ordinary thumb-lancet whenever she suffered more than usual oppression.

In tapping for the relief of the multilocular variety of dropsy, the puncture should be made in the most prominent and fluctuating portion of the tumor, the instrument, which should be large, and at least six inches in length, being afterwards thrust into the smaller cysts until all the accessible fluid has been evacuated. It is seldom that more than one external opening is required.

When the operation is over, the abdomen should be firmly compressed by means of a thickly folded cloth and a broad bandage, in the hope of preventing early reaccumulation. The effect should be steadily maintained for several weeks, and should be aided by attention to the diet, bowels, and urinary secretion.

Simple tapping is by no means always a safe operation. Of 117 cases reported by Kiwisch, Lee, and Velpeau, 16 perished during the first twenty-four hours; nearly as many within the first month; and a still greater number during the first year. I have myself never met with such an accident, except in one instance, although I have performed the operation a large number of times. But, even in that case, death was attributable, not to the operation, but to the imprudence and obstinacy of the patient, who, despite my most earnest remonstrance, went home, a distance of upwards of one hundred miles, on the third day after she was tapped, and died a short time after from peritonitis.

Death has occasionally been produced by the perforation of a large venous trunk, ramifying on the surface of the cyst; and an instance has been related by Scanzoni, in which fatal hemorrhage was caused by the wound of a vessel of an adherent omentum.

Tapping has sometimes been combined with the permanent retention of the canula, in the hope that it might excite inflammation in the sac, and thus cause obliteration. Le Dran, who, in 1736, was the first to employ this procedure, has published two interesting cases of cure by it; and in modern times it has also occasionally succeeded, although in quite a number of instances it has proved fatal, either from peritonitis or constitutional irritation.

Recamier, Kiwisch, and others are advocates of vaginal ovariocentesis. Dr. Noeggerath, of New York, has adduced statistics from various sources, showing that, of 55 cases of this kind, 34 were successful. The operation, as he performs it, consists in drawing off the water with a trocar, and then uniting the edges in the wound of the sac with those in the wound of the vagina. The object is to establish an opening for steady drainage, through which medicated fluids, especially solutions of carbolic acid, may afterwards be injected, with a view to the ultimate obliteration of the sac. This mode of treatment, which is not always free from danger, should, in my judgment, be limited to strictly dropsical cases, attended with more or less bulging of the tumor behind the uterus, thus rendering access very easy without the risk of wounding the peritoneum.

It might be supposed, *a priori*, that the tapping of an ovarian cyst during pregnancy would be followed by miscarriage, or premature labor, but that this is not the case is abundantly proved by the experience of the last fifteen years. Mr. T. Spencer Wells declares that he has repeatedly performed the operation, and never witnessed any bad effects.

Partial Excision.—A cure has now and then followed excision of a portion of the sac, drawn out through a small wound in the linea alba; the rest of the sac being either secured to the edges of the external opening, or permitted to sink into the pelvis. The procedure, however, is one of much hazard, as it is generally succeeded by violent inflammation and death. Nearly one-half of the cases that have been thus treated have perished, so that the operation is, perhaps, more fatal than even ovariectomy itself.

Injections.—Attempts at a radical cure by injections have occasionally been made. Some years ago the operation was quite the fashion, and was only arrested by its want of success, or, rather, by its mortality, which was, on the whole, proportionately very large. Even in many of the cases that were reported as successful, the dropsy eventually returned, and soon attained its former height. The favorite article for injecting the sac was the tincture of iodine, sometimes pure, but more generally considerably diluted, and introduced in quantities varying from one to six or eight ounces, according to the size and age of the cyst. As might have been supposed, the operation was often followed by severe inflammation, leading to copious sero-sanguinolent effusion, and not unfrequently extending to the peritoneum. It must be evident that such a procedure is chiefly applicable to small and recent ovarian cysts, but even here we should hesitate a good while before resorting to it.

The only statistics, on a large scale, of this operation are those supplied by Velpeau, and it is not at all certain that they are reliable. They embrace 130 cases, of which 64 were cured, 30 died, and 36 were temporarily ameliorated. It is proper to add that, in 20 out of the 30 patients who died, the injection was associated with the retention of the canula in the sac for a long period, with a view of facilitating drainage; a procedure which, no doubt, considerably enhanced the danger of the operation. Of 158 cases, collected by Günther, in six of which, however, the result is not given, 32 were cures, 61 failures, and 59 died. Boinet has reported 45 cases, in 34 of which the cyst was simple, and in 11 compound. Of the former 31 were cured, and 3 died, while of the latter there were 5 failures, and 6 deaths. In 4 cases treated in this way by Scanzoni, the result in every one was fatal, and the mortality in the hands of several other practitioners has been almost as great. Simpson, on the contrary, lost only 1 patient out of upwards of 40 after this operation. My conviction, nevertheless, is, that iodine injections, however carefully performed, are fraught with danger, and that, although they may occa-

sionally be productive of temporary benefit, they are seldom, if ever, followed by a permanent cure.

The injection may be performed with an ordinary gum-elastic bag, provided with a long narrow nozzle and a stop-cock, the contents of the sac having previously been thoroughly evacuated with a long trocar and canula. The quantity of fluid to be introduced must vary, according to the age and size of the tumor, from two to eight ounces, which may either be left in the sac, or, if productive of severe pain, be partly withdrawn. The officinal tincture of iodine, diluted with from two to eight parts of alcohol, is the most suitable preparation. The danger of the operation will be materially diminished if the injection be withheld until the second tapping, performed within a short time after the first, as this affords the sac an opportunity of shrinking. The abdomen should be well kneaded in order to bring the fluid in contact with every part of the sac, and care taken that no air is admitted. When the operation is over, the puncture is closed with adhesive plaster, supported by a large compress and a broad bandage. The after-treatment must be strictly antiphlogistic.

Ovariectomy.—Extirpation of the unilocular ovarian cyst has often been attempted; sometimes successfully, at other times with a fatal result, the precise ratio of mortality not having been determined by any reliable statistics. Such an operation, it appears to me, is only justifiable, as a general rule, in the event of rapid reaccumulation after tapping, attended with gradually increasing prostration, rendering it certain that the case, unless speedily relieved, must inevitably end fatally. Under such circumstances, no conscientious surgeon should hesitate to interfere; if the result is unfortunate, life is destroyed only a little sooner than it otherwise would be; if successful, the surgeon achieves a real triumph. In the more ordinary cases the patient may be made comfortable by occasional tapping and attention to the general health.

When the operation is of no avail, and the case is steadily progressing from bad to worse, the tumor not only seriously interfering with respiration, but actually imperilling life, the only resource is extirpation.

The great difficulty in regard to ovariectomy consists, not in its performance, but in knowing when it is absolutely indicated. That there are cases of disease which do not admit of the use of the knife, all educated, honest, and reflecting surgeons are agreed. One of the greatest obstacles to success grows out of the difficulty, if not utter impossibility, in many cases, in arriving at a correct diagnosis, no matter what pains may be taken in the investigation. Hence, it is not surprising that in at least three-tenths of the cases that have been subjected to the knife, the operation had to be abandoned, while, in quite a number of others, no ovarian tumor of any kind was found. No man should be so fool-hardy as to operate in the dark, or at a venture, in the hope that the issue may be successful, when he has no positive assurance as to the character of the disease for the relief of which he is about to assail a human being. The following are the circumstances which, it seems to me, would render ovariectomy proper:—

1st. Simple cysts, attended with rapid reaccumulation after repeated tapping, and a regular, steady, downward tendency, rendering it probable that, if relief be not soon afforded, the disease will prove fatal.

2d. Multilocular cysts, steadily progressive, but without strong adhesions, and accompanied by gradual decline of health and strength.

3d. Solid tumors, of a non-malignant nature, whether fibrous, cartilaginous, or osseous; especially when they are rapidly increasing in size, or have already attained a large bulk, and are attended with ascites and more or less disorder of the general health; provided, of course, that there are no serious adhesions. In this category may be included those tumors of the ovary which are caused by extra-uterine foetation and by conception by inclusion, particularly when there is reason to believe that the patient will perish unless assisted in this way.

On the other hand, an operation may be considered as unjustifiable, 1st, when the tumor, whatever may be its structure, is strongly and extensively adherent; 2dly, when the disease, from neglect, mismanagement, or other causes, has been productive of such a degree of exhaustion as to render it probable that the patient will not be able to bear the shock of the operation; 3dly, when the tumor is unequivocally of a malignant nature; and, 4thly, when it is impossible to arrive at a satisfactory diagnosis, especially after having made an exploratory incision.

No operation, of course, is to be thought of when there is serious organic disease of other organs, as the heart, lungs, liver, or kidneys. The existence of albuminuria is a positive contra-indication to interference, and a similar rule is applicable to extreme depression of spirits. No operation should be undertaken during the prevalence of an epidemic. Early pregnancy is no bar to ovariectomy. Mr. T. Spencer Wells not long ago operated successfully upon a woman who had passed her third month, the tumor weighing thirty-seven pounds. The interest of the case is enhanced by the fact that the cyst had burst before the operation, causing peritonitis, which still existed at the time when it was performed.

Some preliminary treatment is generally proper, but this should not be carried too far, otherwise it may prove prejudicial. The secretions should always be carefully corrected; and, if the patient is debilitated, she should be subjected for at least a fortnight to the use of tonics, especially quinine and iron. Women in robust health do not bear the operation as well as those whose system has become enured to suffering, which thus establishes a certain degree of tolerance to the employment of the knife. Age is no bar to ovariectomy, provided the patient has sufficient strength to bear it, or there are no serious complications. Professor Jouon, of Nantes, lately performed the operation successfully upon a girl only twelve years of age, on account of a large multilocular cyst. The instruments that are required for ovariectomy are, a large scalpel, a probe-pointed bistoury, a trocar, a clamp, a dozen flexible metallic pins, and several long acupressure needles. Only very soft and fresh sponges should be used. Warm and cold water should be at hand, together with a broad double flannel bandage and an ordinary sized breakfast-table, well covered with blankets, and provided with several large pillows.

Ovariectomy is of American origin, having been first performed in December, 1809, by Dr. Ephraim McDowell, of Kentucky. The patient, a married woman, the mother of several children, recovered without any untoward symptoms, surviving the operation thirty-two years. The tumor, partly solid and partly fluid, weighed twenty-two pounds and a half. Until recently it was generally imagined that this operation had been devised and first practised, in 1776, by L'Aumonier, of Rouen; but in my Report on Kentucky Surgery, presented to the Kentucky State Medical Society in 1852, I clearly showed that the case of the French surgeon was one simply of abscess of the ovary and the Fallopian tube, occurring in a prostitute consequent upon parturition. For the purpose of affording free vent to the purulent fluid, which had for some time escaped by the vagina, an incision, four inches in length, was made along the lower edge of the external oblique muscle, when, the diseased parts being separated from each other, the ovary was removed. The organ, which was encysted, was about the volume of an egg, and of great hardness.

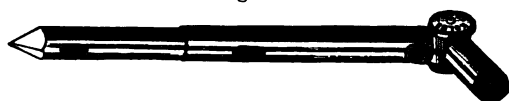
It is believed that Dr. McDowell performed the operation of ovariectomy altogether about thirteen times. His first three cases were published in the seventh, and the last two in the ninth, volume of the Philadelphia Eclectic Repertory. Of these cases, three recovered, one perished of peritonitis, and the other remained well for nearly five years, when the tumor, which had been tapped, but which it was found impossible to extirpate on account of its extensive attachments, recommenced growing, and gradually regained its former bulk. In three other cases, of which I have collected the particulars, the operation, in one, was perfectly successful, while in the other two the tumors were so firmly adherent that it had to be abandoned.

Professor Nathan Smith, of New Haven, in 1822, extirpated an ovarian cyst, containing eight pounds of fluid, from a woman, thirty-three years of age, the mother of five children, who recovered without any grave occurrence. The incision, made along the linea alba, was not more than three inches in length. The next case, also a successful one, which occurred in this country, was that of Dr. David L. Rogers, of New York, in 1829. Removal was effected by the long incision, and the tumor, partly solid and partly fluid, weighed ten pounds and a half.

The operation, as now practised, is performed at the middle line of the abdomen, either by the long or short incision, as it is termed, the choice depending upon the nature of the case, especially the size of the tumor, and the presence or absence of adhesions. McDowell, in his first case, made his incision on the left side, some distance from the outer edge of the straight muscle, its length being nine inches. Subsequently, he cut through the linea alba, the place now universally selected for the operation, the patient lying upon her back on a narrow table, with the head and shoulders well elevated, and the feet resting on a high chair. The bowels and

bladder are thoroughly emptied as a preliminary step. During the operation the patient is kept thoroughly warm and fully under the influence of chloroform. The superficial incision is made with an ordinary scalpel along the linea alba, through the skin and cellular substance, and varies in length, according to the nature and size of the tumor, from five to ten inches. If the tumor is large and solid, the wound must necessarily be proportionately long, otherwise it will be impossible to draw it out without the further use of the knife. If, on the other hand, the contents are fluid, or chiefly fluid, a very short incision, reaching from the pubes, perhaps, half-way up to the umbilicus, will be quite sufficient. In some of the recorded cases the wound has been carried as high up as the xiphoid cartilage. No vessels of any size are divided in this stage of the operation. For the deep incisions the proper instrument is the probe-pointed bistoury, guided upon the index and middle fingers of the left hand. The operation will be greatly facilitated, especially if the tumor be

Fig. 671.



Dr. Mears's Trocar.

unusually bulky, by evacuating its contents, as may always be easily done when they are fluid, with a large trocar, a good form of which is that of Dr. J. Ewing Mears, represented in fig. 671, care being taken that none of the matter escapes into the cavity of the abdomen. The

bowels, during the dissection, are held out of the way by an assistant, and, if necessary, kept warm with flannel wrung out of warm water. The tumor, if perfectly loose, is now separated at its pedicle, previously embraced by the clamp, secured so firmly as to prevent the possibility of hemorrhage. If any adhesions exist they must be broken up with the fingers, either alone or with the aid of the knife, which, however, should only be used as a matter of absolute necessity. The instrument, indeed, must be employed most warily, chiefly for the division of narrow, slender bands; for, if the attachments are uncommonly firm and extensive, such a procedure would inevitably be followed by copious hemorrhage, and violent, if not destructive, peritonitis. If the omentum be inseparably united to the tumor, it must be re-trenched, the stump being tied up in a mass, and fastened in the upper angle of the wound.

The extirpation being completed, the bleeding arrested, and any fluid that may have fallen into the pelvic cavity removed with the sponge, the clamp, fig. 672,

Fig. 672.



T. Spencer Wells's Clamp.

is brought out at the lower extremity of the wound, the edges of which are next approximated by numerous points of the twisted suture, the pins being carried through the peritoneum, in order that, in the event of recovery, the woman may not be annoyed with hernia. The lower angle of the wound is left slightly open, to facilitate drainage, the skin alone being embraced in the stitch. Long adhesive strips are stretched across the intervals of the pins, nearly around the abdomen, which should be still further

supported with a roll of wadding and a broad double flannel bandage.

The woman is now placed in bed, with her head and limbs elevated, to prevent tension of the abdomen, a jug filled with hot water is applied to the feet, the weight of the bedclothes is warded off with cross hoops, and half a grain of morphia is injected under the skin for the triple purpose of allaying pain, inducing sleep, and quieting the bowels, which should not be disturbed for days together, except by an occasional enema, in the event of unusual flatulence and colicky suffering. The anodyne is from time to time repeated; the diet should be bland, concentrated, and nutritious, consisting largely, for the first eight-and-forty hours, of beef essence; thirst is allayed with ice; the urine is drawn off at least every eight hours; and the air of the apartment is kept gently moist at a temperature of about 80° of Fahrenheit. Above all, care is taken not to expose the patient to draughts. As the great danger after this operation is peritonitis, everything should be done to ward off the attack. If serous, sanguinolent, purulent, or sero-purulent effusions occur, the lower extremity of the wound should be partially reopened, to admit of their easy escape, otherwise they may not only cause severe inflammation, but even pyemia. In gene-

ral, indeed, the best plan will be to wash out the pelvic cavity several times a day with a tube and syringe charged with tepid water, slightly impregnated with chlorinated soda, or, what is preferable, a small quantity of permanganate of potassa. Such a procedure is often indispensable to recovery. Dr. Peaslee, who strongly insists upon its importance, and who ascribes the recovery of a number of his cases to its employment, states that in one of his patients not less than 135 injections were used in eighty-four days. The pins should not be removed until there is firm union, and the parts should be well supported for a long time afterwards. The ligature is detached at a period varying from one to several months.

When both ovaries are diseased, they should be removed in immediate succession; an operation first performed by Dr. John L. Atlee, his case, which terminated successfully, having occurred in June, 1843. It has since been executed by Dr. Peaslee, Koeberlé, T. Spencer Wells, A. R. Jackson, and other surgeons. In one of the cases reported by Koeberlé both ovaries were successfully extirpated along with the uterus.

Dr. W. Boinet has reported the case of a woman, forty-eight years old, from whom he successfully removed both ovaries at an interval of ten months. The first tumor weighed nearly thirty-seven pounds, and the second eighteen and a half.

The chief source of the hemorrhage in this operation is the separation of the adhesions, which is often followed by a copious flow of blood caused by the rupture of enlarged veins, which, as they are without valves, are not always easily controlled. When the attachments are so extensive as to carry the peritoneum along with them in the attempt to destroy them, the small arteries of the wall of the abdomen may bleed quite freely, the blood either spirting in a full stream or oozing out at numerous points. When the hemorrhage does not yield to torsion, compression with the finger or sponge, or the use of Monsel's salt, the only thing to be done is to include the vessels, whether venous or arterial, in the grasp of an acupuncture needle, passed through the wall of the abdomen. It is not often that the vessels of the omentum bleed much, even when the adhesions between it and the tumor are old and extensive. Should this, however, be the case, they must be carefully ligated, one of the ends of the thread being brought out at the nearest part of the wound. Several cases of fatal hemorrhage from the wound in the abdomen have been reported; but such an event will hardly happen if the edges have been properly adjusted.

The clamp, of which valuable modifications and improvements have been suggested by W. L. Atlee, Dawson, and others, is undoubtedly the best and safest contrivance for securing the pedicle in this operation. It was first used for this purpose by Mr. Hutchinson, of London, in 1858. There is no risk of its slipping off, if it be properly applied. I can see no objection to searing the raw surface of the pedicle with the hot iron, as suggested by J. Baker Brown, although there does not seem to be any positive necessity for it. Instead of using the clamp, Professor Byford, of Chicago, in a successful case of ovariectomy, in 1860, fastened the pedicle above the pubes with the pins employed in uniting the lips of the wound. Some operators still prefer a stout and well-waxed ligature, either single or double, for securing the pedicle, on the ground that it is quite as safe as the clamp. Instead of bringing the ligature out at the inferior angle of the wound, Mr. Handyside, in order to avoid irritation in a case of ovariectomy, in 1846, carried it through the recto-vaginal cul-de-sac into the vagina, and a similar procedure has occasionally been pursued by other operators. It has been suggested to secure the pedicle with wire, cut off close, and left permanently in the pelvis. To render the operation perfectly safe, the wire should be fastened with a stout pair of forceps, otherwise it will almost be sure to slip, and thus lead to hemorrhage. Dr. W. L. Atlee was, I believe, the first to use the *écraseur* for separating the pedicle; but as this procedure does not always afford complete immunity against hemorrhage, it may as well be dispensed with. The Fallopian tube is sometimes so closely attached to the pedicle as to render it necessary to include it in the clamp. Finally, care must be taken not to pull up the uterus too high into the abdomen; an occurrence which may always be avoided if the incision in the linea alba be carried pretty well down towards the pubes, and the pedicle be not cut off too short.

Statistics.—Among the most extended and reliable statistics of ovariectomy are those of Dr. George H. Lyman, of Boston, published in 1856. They are founded upon an analysis of 300 cases, performed indiscriminately for various kinds of diseases, including the one by L'Aumonier, undertaken for the relief of an abscess of

the ovary and Fallopian tube. Of these cases, the operation was completed by the removal of the tumor only in 208; in 78 it was found to be impracticable; in 10 it was performed partially; and in 4 the result has not transpired.

Of 299 cases in which the result is declared, 179 recovered, and 120 died, or at the rate of a little over 40 per cent. Of the 208 cases in which the operation was completed, 119 recovered, and 89 died, or in the proportion of 42.78 in the 100. Of the 78 cases in which extirpation could not be executed, 55 got well of the operation and 22 died, the result in one not being given. Of the 10 cases in which the tumor was only partially removed, 5 recovered and 5 died.

Of the 88 cases in which the operation could not be completed, the causes of failure, in 68, were adhesions of the tumor; and of these 24 died. In 8 no tumor could be found; and in the remainder it was either uterine, pelvic, or abdominal.

The incision in 117 cases was short; and in these, the operation was completed in 60, of which 37 recovered, and 23 died. Of the 57 cases in which it was abandoned or incomplete, 44 got well, and 13 perished. Of 143 cases of the long incision, the operation was finished in 123, 72 recovering, and 51 dying. Of the 20 cases in which the extirpation was abandoned, or left incomplete, 11 escaped, and 9 were lost. The average age, in 221 cases, was 34.33 years, the youngest patient being 17, and the oldest 68. Both ovaries were removed in 13 cases, of which 8 proved fatal.

The cause of death is given in 85 of the cases. Of these, 36 perished of peritonitis, 20 of hemorrhage, 12 of exhaustion, 2 of shock, 2 of pneumonia, and 2 of diarrhoea. The mortality was least between the ages of 50 and 60, and greatest under 20. The duration of the disease exercised considerable influence upon the result of the operation, recovery happening most frequently when the tumor had existed between three and four years. The difference in the mortality between the married and single was trivial. Finally, the danger of the operation was greatly increased by the presence of uterine and other maladies.

The following table, which comprises the results of the most recent operators, and which I have compiled from various sources, throws additional light upon the rate of mortality of ovariectomy. Some of the statistics of the English and German operators are given on the authority of Dr. Grenser, while those of American surgeons are principally derived from the third edition of Dr. T. Gaillard Thomas's Treatise on the Diseases of Women.

Table of 1408 Cases of Ovariectomy.

Operators.	Cases.	Recoveries.	Deaths.
T. Spencer Wells	400	293	107
C. Clay	210	188	72
Kimball	130	86	44
Baker Brown	120	84	36
Keith	100	81	19
Dunlap	69	42	27
Koeberlé	60	48	12
J. L. Atlee	85	28	7
Nussbaum	84	18	16
Bradford	81	28	8
Bryant	28	17	11
Peaslee	26	17	9
White	25	17	8
Thomas	24	17	7
McRuer	22	16	6
Sköldberg	21	17	4
Emmet	17	8	9
Tyler Smith	17	14	3
Spiegelberg	16	10	6
Willett	12	4	8
Sims	11	10	1
	1408	993	415

An inspection of the table shows that the mortality of ovariectomy is 29 per cent., or in the proportion of 1 death in every 3½ cases. This result corresponds very closely with that obtained by Dr. Washington L. Atlee, who has operated 255 times with a loss of about 30 per cent., and, when compared with that of the earlier cases, exhibits a decided gain; a circumstance, apparently, mainly due to the recent improvements in the operation itself and to a more judicious after-treatment. In the

practice of individual surgeons the death rate appears to be steadily diminishing as experience increases. Thus, Dr. Keith in his last 50 cases had a gain of 6 per cent. over the first 50, while Mr. T. Spencer Wells, who lost 34 of his first 100 cases, has lost only 28 of his second 100, 23 of his third 100, and 22 of his fourth 100.

SECT. III.—DISEASES OF THE FALLOPIAN TUBE AND BROAD LIGAMENTS.

Owing to the great difficulty of their diagnosis, the diseases of the Fallopian tube offer, surgically considered, little of interest. In fact, the only one that requires any particular notice in a work of this kind, is dropsy. Incidentally it may be observed that the tube is liable to displacements, morbid adhesions, inflammation, abscesses, hypertrophy, tuberculosis, carcinoma, and different kinds of tumors.

Dropsy of the Fallopian tube, fig. 673, is most common in middle-aged and elderly women who have borne children; the disease may be single or double, and is usually associated with organic lesion of the ovary, uterus, and pelvis. The cause of the affection is, in the first instance, occlusion of the orifices of the tube, which is thus

Fig. 673.



Dropsy of the Fallopian Tube.

placed in the condition of a shut sac. Gradually the mucous lining is transformed into serous tissue, which, taking on inflammatory action, pours out the fluid, upon the presence of which the dropsy depends. This fluid is perfectly clear and limpid, saline in its taste, and coagulable by heat, alcohol, and acids. In its size the cyst—for so it may be termed—varies from that of the small intestine to that of a fist, or even a foetal head; it is of an elongated, conical shape, convoluted, folded, or bent upon itself, much larger at its fimbriated than at its uterine extremity, and irregularly constricted upon the surface, or divided by tight fibrinous bands. A number of vessels, tortuous and varicose, generally ramify over its exterior.

The symptoms of tubal dropsy are generally so closely merged in those arising from disease of the ovary as to render it extremely difficult to discriminate accurately between them. The most important diagnostic signs are, 1st, the remarkable mobility of the tumor in the pelvis, where, unless it is of extraordinary size, it may be freely pushed about independently of the uterus; 2dly, its elongated, conical form, with the rounded base corresponding to the fimbriated extremity of the tube; and 3dly, its wavy, convoluted outline, or its undulated and indented surface, as if fibrous bands were stretched across it. The cyst is smaller than in ovarian disease, and seldom ascends materially above the level of the pubes. The difficulty of the diagnosis will be lessened, if, as suggested by Sir J. Y. Simpson, the pelvic organs be examined simultaneously with both hands, one being placed over the fundus of the womb on the hypogastrium, while two of the fingers of the other are inserted into the vagina and anus, so as to make pressure in opposite directions. If all other means fail, recourse is had to the exploring needle, passed through the roof of the vagina. The escape of a clear, limpid, saline, and coagulable fluid will generally determine the true nature of the case.

The only treatment for this disease is tapping, performed with a delicate trocar, introduced through the upper and lateral portion of the vagina, pushed behind the broad ligament, at the posterior surface of which the cyst is situated. The fluid is drained off gradually, and a sufficient degree of inflammation generally succeeds to counteract any tendency to further secretion. Simpson, in eight instances which he thus

treated, was not obliged to repeat the operation in a solitary one. If paracentesis fails, a little dilute tincture of iodine may be thrown into the sac. Some vigilance is necessary, in either case, during the after-treatment, as the resulting inflammation may be too severe.

Examples are recorded in which rupture of a Fallopian cyst occurred from overdistention, ulceration, external violence, or severe bodily exertion, quickly followed by effusion of its contents, and fatal peritonitis.

The broad ligament is occasionally the seat of different tumors, more especially the cystic and fibroid. Their origin is undetermined, their progress generally tardy, and their diagnosis obscure, it being difficult, if not impossible, to distinguish them from similar affections of the ovary and uterus. A rare case of colloid growth, apparently springing from the broad ligament, and successfully removed by the abdominal section, was lately reported by Dr. John E. Owens, of Chicago. It reached as high as the umbilicus, was of a red, purplish color, and consisted of a hard, fibrous stroma, the alveoli of which were filled with a thin, jelly-like substance. Two similar but much smaller tumors were attached to the uterus.

SECT. IV.—AFFECTIONS OF THE VAGINA.

The vagina is liable to various congenital malformations, inflammation, morbid occlusion, polyps, varix, prolapse, and different kinds of tumors.

a. The tube is sometimes absent, as a congenital defect. Of this variety I have seen three cases, all occurring in young married women. The breasts in all were well developed, and the sexual desire was quite as strong as in the natural state, thus rendering it extremely probable that there was no defect on the part of the ovaries. A careful examination by the finger in the rectum, and a catheter in the bladder, showed that the septum between these two organs consisted simply of their opposed walls.

The vagina is sometimes very short, not, perhaps, exceeding a few lines, half an inch or an inch in extent. When the defect is associated with absence of the urethra, the tube terminates in a cul-de-sac. Cases occur in which it opens into the bladder, or into the rectum, thus receiving the contents of these reservoirs. A double vagina is uncommon. A septum in this condition extends the whole length of the tube, dividing it into two cylindrical canals, each of which terminates inferiorly by a separate aperture. Callisen refers to two cases in which the canals thus formed were closed each by a perfect hymen. In some instances, the septum is situated transversely, constituting a kind of diaphragm, which prevents the flow of the menstrual fluid. Lastly, the tube may be present, and be well developed, but closed by a hymen or by solid matter.

Some of these malformations admit of relief; others do not. Nothing is to be done when there is an absence of the vagina; the woman is impotent, and, therefore, disqualified for marriage. When the tube exists, but is closed by a gristly growth or membrane, surgical interference will be necessary, consisting, generally, in a few simple incisions. When the rectum terminates in the vagina, a proper outlet must be made for it with the knife, an operation which is usually very easy, as the orifice nearly always exists very low down. A vagino-vesical opening should be closed by suture.

β. *Foreign bodies*, as pessaries, glass bottles, and pieces of wood, are occasionally inserted into the tube, where, if allowed to remain for any length of time, they are sure to cause severe inflammation, attended with exquisite pain and tenderness, and the most offensive discharge, simulating that arising from malignant disease. When they keep up constant pressure, ulceration may occur, so as to establish a communication with the bladder or rectum, and the vagina is then also liable to become greatly contracted. Riddance of the intruder may generally be effected, although sometimes not without much difficulty, with the fingers and forceps. When the resistance is excessive, it may be necessary to break the foreign body, or divide it with a saw, each piece being afterwards extracted separately.

γ. The vagina is liable to ordinary and specific *inflammation*. The disease is marked by the usual anatomical characters, and is often attended with a profuse discharge of purulent matter, of a very acrid nature, and mixed, at times, with blood. In bad cases, abscesses are formed in the submucous cellular texture; and instances are witnessed where the parts are rapidly destroyed by gangrene. A coating of ad-

ventitious membrane is sometimes observed, especially when the inflammation is connected with disease of the mouth and neck of the uterus. Occasionally, again, there is a remarkable hypertrophy of the papillæ, giving the surface of the vagina a peculiar granular appearance, the bodies standing out like so many round, shot-like projections, of a vivid red color. The affection is particularly common during pregnancy, but is also met with both in ordinary and in specific vaginitis.

Ulcers of the vagina are generally referable to the syphilitic, carcinomatous, or scrofulous poison, and do not differ from those of the same class of sores in other regions of the body.

A peculiar irritable ulcer, crack, cleft, or *fissure*, is sometimes met with at the mouth of the vagina, chiefly at its posterior commissure, as a consequence, generally, of the slight laceration of the perineum so liable to occur during first labor. It is usually very superficial, seldom, if ever, extending beyond the mucous membrane, and is often extremely painful, especially in walking, defecation, and sexual intercourse, or when urine is brought in contact with it, which always causes severe burning and smarting. The edges of the ulcer are red, rough, everted, and slightly elevated, its surface being incrustated with aplastic lymph, and the seat of a thin, sanious discharge. If neglected, the disease may last for years, and produce great local and constitutional distress with progressive emaciation and debility.

The nature of these different lesions may be suspected when there is more or less copious discharge, but can only be positively determined with the speculum.

The treatment is antiphlogistic; by rest, purgatives, and light diet, with astringent injections, as solutions of lead, zinc, alum, or copper. If ulceration exists, nitrate of silver or acid nitrate of mercury may be necessary. Separation of the opposed surfaces with a tent of cotton, charpie, or patent lint, wet with some medicated lotion, as Goulard's extract, acetate of lead, or subsulphate of iron, or smeared with very dilute ointment of the nitrate of mercury, will always greatly expedite the cure. In granular vaginitis great benefit often results from the use of a strong solution of chromic acid. The treatment of specific vaginitis is briefly discussed in the section on gonorrhœa.

The most effectual remedy for fissure of the vagina is free scarification, forcible dilatation with the thumbs, or complete division of the part, precisely as in fissure of the anus. Sometimes the milder cases recover under the use of nitrate of silver.

Children of a scrofulous temperament, and of a weak, relaxed habit of body, are very liable to inflammation of the vagina, or, rather, of this canal and of the vulva. It sometimes comes on within a very short time after birth, and is often met with during dentition, but is most frequent from the second to the seventh year. The exciting causes are various. In the great majority of instances the disease is manifestly dependent upon disorder of the general health, the strumous diathesis, dyspepsia, constipation of the bowels, anemia, the presence of ascarides, or the irritation of a tooth. Want of cleanliness sometimes produces it. The discharge is usually of a thin, whitish, muco-purulent character, not very profuse, somewhat fetid, and more or less acrid, often slightly eroding the skin with which it comes in contact. Occasionally it is sanious, sanguinolent, or mixed with flakes of lymph. The affected surface, seldom very red, is sometimes studded with aphthæ, and there are cases in which it exhibits a fissured, eczematous, or excoriated appearance. The vulva commonly suffers more than the vagina. When the disease is neglected, it may be protracted into puberty before it finally disappears.

Slight as this affection commonly is, it is very often a source of great annoyance to the parents of the child, especially when the discharge is unusually profuse, under an apprehension that it has been communicated by personal contact. Such an opinion should always be promptly discountenanced. Numerous trials for rape have grown out of an erroneous diagnosis in cases of this kind, much to the discredit of the professional attendant.

The treatment of this variety of leucorrhœa consists, first, in removing, if possible, the exciting cause; secondly, in invigorating the general health, by tonics, nutritious diet, and change of air; thirdly, in the observance of perfect cleanliness; and, lastly, in the use of mildly astringent washes and injections. Leeches and nitrate of silver may be necessary when the inflammation is unusually severe, obstinate, or protracted.

8. *Hemorrhage* of the vagina is usually the result of external injury, and must be treated by ligation of the bleeding vessels, if practicable; by plugging and astringents, if not. Exposure of the part to the cold air and the application of ice will

also prove beneficial. I have thrice seen very copious bleeding from laceration of the lower extremity of the vagina from the effects of copulation.

New-born children are liable to a discharge of red, fluid blood, from the vagina, or vagina and vulva, which often continues without any material interruption for several days and even weeks. The affection is unattended by any of the ordinary evidences of inflammation, such as discoloration, pain, heat, or swelling, and there is no perceptible derangement of the general health. What its precise source and nature are has not been determined. It is always free from danger, and usually disappears of its own accord, the only thing required in the way of treatment being attention to cleanliness.

1. *Occlusion of the vagina* is observed chiefly in married females, as a result of severe and neglected inflammation after delivery. Children and young girls, however, are by no means exempt from it. The affection occurs in several varieties of form and degree. In the milder cases, the adhesion generally exists very low down, merely as a slight agglutination of the contiguous surfaces; but, under opposite circumstances, the union may be complete, reaching from one end of the tube to the other. Such an effect may be the result of ordinary inflammation, and is then a comparatively simple affair, especially if it has not been too long neglected; very frequently, however, it is caused by injury done to the parts during labor, eventuating in gangrene and sloughing, and the ultimate development of an inodular, inextensible tissue, rendering the case one almost of a hopeless character.

The only remedy for this affection is the separation of the contiguous surfaces, which, as already hinted, is occasionally easy enough. When the case is a slight one, the fingers alone sometimes suffice for the purpose. At other times the operation is readily performed with the handle of the scalpel, aided, perhaps, by a few touches with its cutting extremity. But the task is a very different one when the adhesion is firm and extensive. In such a case nothing but the most patient and cautious dissection will suffice, the knife being carried up in the natural direction of the tube, while the left index-finger is in the rectum and a catheter in the bladder, to serve as guides to the instrument, lest it should penetrate these cavities, and thus cause an intestinal or vesical fistule. Moreover, the operation is not undertaken without due preparation of the system, and a statement of its dangers. I have myself seen two women speedily perish from peritonitis induced by attempts to reëstablish the vagina, although I am perfectly certain that the operation could not possibly have been better done.

The after-treatment in these operations must be conducted with great care and vigilance. A well-oiled tent of patent lint is inserted, to prevent readhesion of the contiguous surfaces, renewal being effected whenever it is demanded by cleanliness. When the cicatrization is completed, a gum-elastic bougie should frequently be introduced, to restore the tube to its normal diameter. When there has been loss of substance of the vagina, even to a slight extent, incessant vigilance will be required to counteract the tendency to contraction and readhesion.

2. *Stricture of the vagina*, properly so called, from morbid deposits within its walls or the presence of firm cicatrices, is occasionally met with, and may require attention on account of its interference with coition, parturition, and cleanliness. The milder cases will generally yield to dilatation; in the more severe, free incisions, aided by tents of compressed sponge, will be necessary. Firm cicatrices, obstructing the descent of the child's head, must be thoroughly divided, by two or three small incisions on each side of the vagina, the operation being performed during the existence of a labor pain, when the parts are upon the full stretch. The anterior and posterior walls of the tube should not be interfered with, lest the bladder and rectum be endangered. Large incisions should be avoided.

3. *Fibrous or myomatous tumors* sometimes occur in the walls of the vagina as intraparietal growths, forming comparatively soft structures, capable of attaining the volume of a double fist. They are readily enucleated. Occasionally they assume the form of *polyps*, but in this event the mass is made up of fibrous tissue, only one instance, that of Scanzoni, being recorded in which muscular elements were present. Tumors of this description may attain a very considerable magnitude, so as to distend not only the whole tube, but project some distance down between the thighs. Their weight has been known to exceed ten pounds. The proper remedy is evulsion or ligation.

4. *Prolapse of the vagina* is most common after middle age, in married females

who have borne children, and who have long suffered under a relaxed condition of the genito-urinary apparatus. The disorder, which is generally combined with, if not directly dependent upon, prolapse of the uterus, may be limited to the anterior or posterior wall of the tube, or it may embrace its entire circumference. In the latter case, the vagina forms a large tumor, soft, elastic, and of a red, bluish, or lead color, passing beyond the vulva, and hanging down between the thighs, as in fig. 674. In prolapse of the anterior wall, there is generally a descent of the bladder, which exhibits itself as a globular or ovoidal swelling at the upper part of the vulva, and which may be greatly reduced in size, if not entirely effaced, by catheterism.

Considerable irritability of the bladder generally accompanies this complaint, attended with a frequent desire to micturate, and more or less tenesmus. As the organ can never entirely empty itself, the retained urine soon becomes decomposed, fetid, and surcharged withropy mucus, or mucus and pus.

Prolapse of the vagina is liable to be confounded with protrusion of the uterus and polyps of this organ. The principal points in the diagnosis are the soft and compressible character of the tumor, and its conical, globular, or ovoidal shape. In prolapse of the uterus, the swelling is hard, and the examiner may always readily determine the existence of the orifice of the organ. A polyp is firm, incompressible, and irreducible. In prolapse of the anterior wall of the vagina, constituting what is usually termed *vaginal cystocele*, the tumor enlarges as the urine accumulates, and diminishes during its evacuation.

The treatment of this affection consists, in its earlier stages, in the use of astringent injections, and of medicated tents, large enough to oppose the descent of the parts, and retained by an appropriate apparatus. In the anterior protrusion, the bladder should be frequently emptied, to prevent the pressure of the water from forcing down the tumor, and the uterus should be well supported with a stem pessary, worn steadily for several months, the woman being nearly all the time recumbent. By careful perseverance with this treatment, an excellent cure may occasionally be effected in a very short time, even in cases of an apparently unpromising character.

When the cystocele is of long standing, or unusually obstinate, an elliptical portion of the mucous membrane of the vagina may be carefully dissected off, and the edges of the wound brought together by several points of the interrupted suture; the object being retrenchment of the redundant structures. In the posterior descent, special attention must be paid to the state of the bowels, as straining and the impaction of fecal matter are the most frequent causes of the complaint.

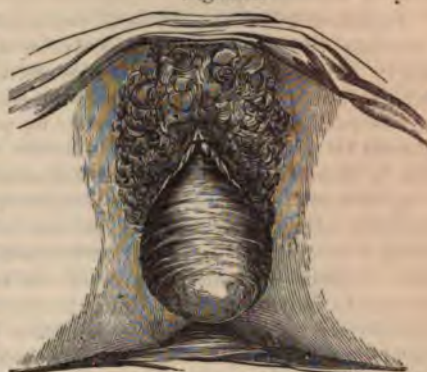
When the case is utterly intractable, and the woman has passed the menstrual period, the orifice of the vagina may be almost entirely closed by paring the surfaces of the labia, and uniting them by suture, as in the more aggravated forms of prolapse of the uterus.

c. A *cystic tumor*, consisting in a morbid enlargement of one of the mucous follicles, is sometimes observed in this tube. It has a strong, thick, fibrous wall, with a polished internal surface, and is occupied by a clear, glairy, yellowish, viscid fluid. Seldom exceeding the volume of a chestnut or a pigeon's egg, it is more or less tense, but fluctuating, tardy in its growth, very sensitive, and, at times, even painful.

On one occasion I saw a growth of this kind immediately beneath the orifice of the urethra in a young lady, the mother of four children. It was of a spherical shape, about the size of a walnut, and of a white, glossy appearance, with a rough, corrugated surface. It had existed for eight years. The tumor was freely opened with the lancet, the incision giving vent to a considerable quantity of a viscid, glairy fluid, like the white of egg, and the parts were soon permanently healed.

x. A *papillary tumor* is occasionally developed in the vagina, particularly in its upper portion, where it forms an irregular, very vascular, cauliflower-like excres-

Fig. 674.



Prolapse of the Vagina.

cence, which is liable to bleed under the slightest irritation. It consists essentially of hyperplasia of the normal papillæ, and resembles in every respect similar growths of other mucous surfaces. The proper remedy is excision, followed by the application of chromic acid.

Females, after the fortieth year, are liable to *epithelioma* of the vagina, which presents the same general features as carcinoma of the uterus. Occurring as a warty or cauliflower-like excrescence, it progresses rapidly, ulcerates, is attended with a foul, sanious discharge, and soon contaminates the iliac and sacral glands. In its earlier stages, with a view to prolong life and allay suffering, free excision should be practised. When, however, the disease has made much progress, nothing can be done beyond palliation and attention to cleanliness.

1. Under the name of *vaginismus*, Dr. J. Marion Sims, in 1862, described a peculiar affection of the vagina, previously noticed by Michon and Debout, characterized by painful spasmodic contraction of its sphincter muscle, accompanied by such a degree of sensitiveness of the surrounding structures as to form a complete barrier to coition and to the introduction of instruments. Its discovery is generally purely accidental. The gentlest touch with the finger, a probe, a feather, or even a hair pencil, causes the most exquisite agony. Every portion of the outlet of the vagina is sensitive, but often the most tender point of all is at the fourchette. The hymen is usually thick and voluminous, and the orifice of the vagina is as firm and unyielding as if bound by a firm cord. The sphincter muscle of the anus, in many cases, feels almost as hard as a ball of ivory. The general health is commonly much deranged, the patient being exceedingly nervous, impressible, and wretched. The affection, which is occasionally accompanied by marked evidence of inflammation, as patch-like redness and enlargement of the mucous papillæ, is invariably complicated with rectal and vesical irritation. Its exciting cause cannot always be ascertained.

The pathognomonic sign of *vaginismus* is spasm of the sphincter muscle of the vagina; the diagnostic, supersensitiveness of the surrounding surfaces. The only affections with which it is liable to be confounded are occlusion of the vagina and the existence of an imperforate hymen. The disease obviously possesses a strong resemblance to anal fissure.

The treatment which has been found to be most efficacious in *vaginismus* is free division of the affected parts. The patient being fully anæsthetized, and placed on her back, as in the operation for lithotomy, the surgeon inserts the left index and middle fingers into the vagina, and, separating them laterally as widely as possible, thus puts the fourchette well on the stretch. A deep cut is then made with a common scalpel through the resisting tissues, on each side, from ten to fifteen lines in length, commencing a short distance above the upper border of the sphincter muscle, passing across its substance for a short distance, and terminating at the raphe of the perineum. If the hymen be thickened, red, and supersensitive, it should be thoroughly removed at the same time. Any hemorrhage that may attend is easily controlled with Monsel's solution. To complete the cure, a suitable dilator—generally one of glass or of gilt metal—is worn until the incisions are cicatrized. Sometimes relief may be procured simply by incising the mucous and submucous cellular textures.

In the milder cases of this affection, as in several instances under my care, relief has occasionally been afforded by forced dilatation with the fingers, employed in the same manner as in the treatment of fissure of the anus. Raciborski has reported a case of excessive *vaginismus* in which a rapid and complete cure was effected by the use of bromide of potassium.

SECT. V.—AFFECTIONS OF THE HYMEN.

The principal affections of the hymen are inflammation, ulceration, laceration, imperforation, and inordinate rigidity, interfering with copulation, parturition, and menstruation.

Inflammation of the hymen is no doubt often primary, but more frequently secondary, or the result of an extension of the morbid action from the adjacent parts, as the vagina, nymphæ, or vulva. It may be acute or chronic, simple or specific, diphtheritic, eczematous, or erysipelatous, and must be treated upon general principles; by rest, recumbency, laxatives, saturnine lotions, injections, and isolation of

the vulva. In young children, laboring under vaginitis, much of the discharge attendant upon the morbid action is derived from the hymen.

Ulceration of the hymen is most commonly of a specific character, being caused by the contact of the syphilitic virus, and must be treated by gentle cauterization with nitrate of silver, cotton tampons wet with a solution of tannic acid in glycerine, and charpie anointed with dilute ointment of acid nitrate of mercury.

Laceration of this membrane is often followed by considerable pain and hemorrhage, requiring rest, cold applications, and sometimes even styptics, as pounded ice and subsulphate of iron.

When the hymen is torn irregularly, the shreds may be so much in the way of convenience and comfort as to call for the use of the knife or scissors. In a case narrated by Boivin and Dugés, an excrescence of this kind, of a pyriform shape and reddish color, adhered to the posterior part of the right nymphæ, and was two inches in length at the time of its removal, which was followed by a copious hemorrhage, for the arrest of which it was necessary to cauterize the raw surface and plug the vagina.

Surgical interference may be required when the hymen offers a serious barrier to sexual intercourse, to the descent of the child's head in labor, and to the evacuation of the menstrual fluid. The membrane, however, is commonly so thin and fragile as to give way under the slightest force, and it is, therefore, seldom that any particular injury is sustained, whether the laceration is effected accidentally or designedly. A little blood may flow, and for a few days the parts may be sore and tender; but the trouble soon ceases; the angles of the wound shrink; and no further complaint is made. Division of the membrane is always easily effected with a probe-pointed bistoury.

Division of the hymen for the relief of retained menses is often followed by very serious consequences, and should, therefore, be performed with the greatest possible care. The plan formerly adopted was to make a free crucial incision, so as to admit of rapid drainage; but, experience having shown that the operation when thus executed is liable to occasion peritonitis, the method now generally pursued is just the opposite one; that is, the membrane is pierced with a delicate trocar, the opening being made purposely small to allow the uterus time to contract upon its contents as they slowly dribble away. The danger of the old operation appears to depend upon the fact that the large cavity left after the rapid evacuation of the tumor is speedily followed by the decomposition of what fluid remains in the womb, and that this occurrence, in its turn, is soon succeeded by a slow form of irritative fever, similar to that engendered by pyæmia, and almost equally destructive. In other cases, again, the operation is followed by the rupture of one of the Fallopian tubes, which are always more or less distended with menstrual fluid, and the escape of which into the sac of the peritoneum invariably excites violent, if not fatal, inflammation.

The diagnosis of retention of the menstrual fluid dependent upon the presence of an imperforate hymen is determined by the history of the case and by a careful examination of the parts. More or less severe pain will be experienced at every monthly period, without any discharge in the natural direction, and the vagina will gradually become distended by the accumulated fluid, forming ultimately a pelvic tumor, readily detectable by the finger in the rectum and by the sight and touch upon separating the vulva, where there is often a marked bulging, of a dark-bluish or livid color. The fluid, as it increases in quantity, not only completely fills the vagina, but distends the uterus, and, as already stated, even the Fallopian tubes, which, in consequence, sometimes acquire the volume of a finger, or even of the small intestine. If the obstruction is not removed, one of the tubes may give way, and thus allow its contents to escape into the peritoneal cavity, followed by fatal inflammation; or, instead of this, the fluid may find a partial vent through the rectum, bladder, or urethra, although such an occurrence is very uncommon.

SECT. VI.—AFFECTIONS OF THE VULVA.

1. *Labia*.—The great lips are liable, during delivery, to *hemorrhagic* infiltration from a rupture of some of the neighboring vessels. The lesion usually involves only one of these organs. The tumor which is thus formed is generally of an irregularly oblong shape, with a dark livid surface, more or less compressible, and

about the size of a hen's egg. Occasionally, however, it is much larger, equalling the volume of a fetal head, and containing from ten to twenty ounces of blood. The effusion commonly takes place suddenly, or in a very short time, and, when copious, it almost always makes its escape spontaneously, by lacerating the superincumbent textures, or it remains, and speedily induces inflammation and gangrene. In the latter case the blood is generally of a very black color, partly fluid and partly coagulated, and emits a highly offensive odor. The infiltrated tissues are sometimes frightfully lacerated, and converted into a dark, shreddy substance, without any trace whatever of their original characters.

When the tumor is small, it will usually soon disappear under cooling, sorbefacient applications, as solutions of acetate of lead, alum, or hydrochlorate of ammonia, along with opium; but, under opposite circumstances, the only effectual remedy is prompt evacuation by free incision.

The labia are liable to incised, lacerated, and contused wounds, the chief interest of which arises from the excessive swelling and hemorrhage that so often attend them. Numerous cases have been reported in which the bleeding, in incised wounds, was so copious as to prove fatal in a few hours. The treatment involves nothing peculiar. Acupressure is sometimes required to arrest the hemorrhage.

Inflammation of the labium may be produced by various causes, and requires the usual remedies for its subdual. The formation of matter will be denoted by increase of heat and swelling, the inordinate hardness of the part, and the throbbing character of the pain. Relief is afforded by an early and free incision, the surgeon not always waiting for distinct fluctuation.

A chronic *abscess* sometimes occurs here, as in the case of a married female, twenty-six years of age, who came to me with a swelling in the left labium of nearly four months' standing, hard, free from pain, and without any constitutional disturbance. The insertion of an exploring needle was followed by an escape of pus, which, when fully evacuated, amounted to upwards of five ounces.

The external lip may be the seat of different kinds of *ulcers*, either simple or specific, most commonly seated upon its mucous surface, or at the junction of this surface with the cutaneous. The disease sometimes affects the mucous follicles, the sore presenting itself in the form of a small depression, perhaps not larger than a pin's head. The chancreous ulcer is generally readily distinguished by its history, its large size, its tendency to spread, its obstinacy, and the abundance of the attendant discharge. The common ulcer is often occasioned by want of cleanliness, friction, or disorder of the digestive apparatus.

The treatment of ulceration of the vulva must depend upon the nature of the exciting cause. The most important remedies are frequent ablutions with soap and water, and astringent lotions, applied by means of patent lint in such a manner as to insure constant isolation of the opposed surfaces. Recumbency, light diet, and purgatives are indispensable auxiliaries. If the ulcers have a tendency to spread, they should be gently touched once a day with a weak solution of acid nitrate of mercury. The indurated chancre may require slight pyalism.

Gangrene of the vulva is uncommon. It is most liable to occur in worn-out, intemperate, anemic females, as a consequence of syphilis, and must be treated upon general principles.

Mr. Kinderwood, many years ago, described a fatal disease of the vulva of young children, which, commencing at one or more points of the mucous surface, rapidly spreads over the nymphæ, clitoris, and hymen. Gangrenous spots appear in a very short time, and continue to enlarge until the parts are converted into dark-colored, fetid sloughs. Great prostration of strength, accompanied by fever and severe pain, is the most prominent symptom of the complaint. The treatment consists of tonics, milk punch, anodynes, and the application of dilute acid nitrate of mercury, with warm water-dressing, simple or medicated.

Edema of the vulva is occasionally witnessed; chiefly during the latter months of pregnancy, or soon after delivery, and in females of a broken constitution, in combination with ascites and anasarca. Enormous tumefaction, either circumscribed, or more or less diffused, may thus be produced, terminating, unless timeously relieved, in severe suffering, if not in gangrene. The proper remedy consists in the removal of the exciting cause, and a few minute punctures, to admit of the escape of the pent-up fluid, followed by astringent lotions, or pencilling of the affected parts with dilute tincture of iodine.

Erysipelas of the vulva is usually of the œdematous character; the disease is easily recognized by the nature of the pain and swelling, and is treated upon general principles, early and free incisions forming an important element of the management.

Fistule of the vulva is generally caused by an imperfectly healed abscess or ulcer, and is often a very troublesome complaint, keeping up discharge and irritation. It may be limited to the labium, or extend into the vagina, perineum, anus, or even the bladder. The diagnosis can only be established with the probe. A cure may sometimes be effected by strong injections of iodine, but the best and speediest remedy, by far, is the free division of the parts with the blunt-pointed bistoury. The operation, however, is liable to be followed by profuse venous hemorrhage, and should, therefore, be conducted with proper circumspection.

There is a form of inflammation of the vulva, which, occurring at different periods of life, but especially in married females, has its principal seat in the *mucous crypts*. It usually shows itself in small patches, of a red, almost scarlet complexion, studded with minute points, which are slightly elevated above the surrounding level, and perfectly distinct from each other. As it progresses, the points increase in volume, and ultimately coalesce, so as to impart to the surface a rough, granulated appearance. At this stage, and, indeed, often before the morbid action has reached this height, some of the glands become ulcerated, the sore looking, at first, like a mere speck, but gradually growing larger and larger until it has acquired the size of a split currant or small pea, its edges being steep, ragged, and, perhaps, partially undermined. The affection is, in every respect, analogous to follicular ulceration of the bowel.

The crypts are liable to chronic inflammation, attended with hypertrophy. When thus affected, they present the appearance of little vesicles, charged with a thick, mucous fluid, not unlike the white of egg, or the contents of the enlarged follicles which are sometimes seen upon the lips of the uterus. These appearances are well illustrated in fig. 675.

In the treatment of this affection the most suitable local remedies are leeches, astringent lotions, and nitrate of silver. When it assumes the chronic form, great relief will be afforded by weak citrine ointment. Rest, light diet, and purgation are important auxiliaries.

Pruritus of the vulva, or eczema of the mucous membrane of the vulva and vagina, is often met with, both in single and married women, but more especially in the latter, and is frequently a source of very great distress, from the violence of the accompanying itching. The disease is most common in females with light hair and eyes, and is generally dependent upon disorder of the digestive apparatus. It is often associated with leucorrhœa, and is so constant an attendant upon diabetes that some authors look upon it as a diagnostic sign of this affection. The parts, which are frequently very dry, have usually a cracked, chapped, or fissured appearance. Minute vesicles, resting on a reddish base, are sometimes present. There is seldom much discharge at the immediate seat of the disease.

The treatment is very uncertain. The most reliable remedies are steady purgation, a restricted, cooling diet, frequent ablutions, inunctions with benzoated zinc ointment, and the application of solutions of borax, acetate of lead, and bichloride of mercury, of which the latter is one of the best. Hot water often affords temporary relief. If plethora exist, blood may be taken from the arm, or by leeches from the groins and vulva. If, on the contrary, the patient is anemic, chalybeate tonics should be prescribed, and the very best, as a general rule, is the tincture of chloride of iron, either alone or in union with quinine.

Fig. 675.



Follicular Disease of the Vulva.

Inversion of the *hairs* of the labia, an affection first described, in 1862, by Dr. Meigs, and closely resembling trichiasis, is occasionally met with, and may become a source of great suffering from the teasing irritation which it keeps up in the mucous membrane, attended with great redness and excessive itching. The remedy consists in pulling out the stiff and incurvated hairs with a pair of tweezers.

Papillomas or warty excrescences are often seen upon the labia, extending, in some instances, into the vagina, and down the perineum as far as the margin of the anus. Their number may be very great. I have occasionally counted upwards of a hundred, of all sizes, from a mustard-seed to that of a raspberry. Usually they are of a pale, florid color, of a fibroid consistence, rough on the surface, pedunculated, and somewhat painful on pressure. Occasionally they are grouped together, running into each other, and thus forming large, irregularly fissured, or cauliflower-like masses. Their origin, in most cases, is referable to the effects of the gonorrhœal syphilitic poison.

The treatment is similar to that of warty excrescences upon the penis. The most efficacious remedy is chromic acid, applied every other day, the parts being in the mean time thoroughly isolated. The largest growths occasionally require excision. If the disease is very rebellious, slight ptyalism may be useful.

Polyps of the vulva are of very infrequent occurrence. They are generally of a pyriform figure, conical, or globular, and attached by a long, narrow pedicle. In volume they vary between an almond and a child's head, although they rarely exceed that of the fist. Occasionally they are so large as to hang down between the knees. At an early period they are of a spongy consistence, and of a bright florid color; but they are liable to become hard, and to assume a pale, mottled appearance, especially when they project beyond the vulva. Ulceration occasionally occurs, followed by a copious discharge of bloody, fetid matter. Their structure is usually of an œdematous, fibrous nature, either uniformly, or interspersed with cysts, or masses of fibro-cartilage. The only remedy is removal with the knife, écraseur, or ligature.

The labia, nymphæ, and lower part of the vagina are sometimes the seat of *varicose veins*, as seen in fig. 676; the disease, which is most common in middle-aged

Fig. 676.



Varicose Veins of the Vulva.

subjects, is usually associated with varicose enlargement of the veins in the inferior extremity, and is liable to great aggravation during pregnancy and delivery. The veins are spread out in an irregular arborescent manner, and may be many times the natural size. The coats of the vessels may be entirely healthy, but more frequently they are diseased, being attenuated at one point, and thickened at another. In some cases the lining membrane becomes inflamed, causing coagulation of the blood, and the formation of pus. During parturition, the enlarged veins may be ruptured by the pressure of the child's head, inducing copious, if not fatal, hemorrhage. No treatment is generally required beyond an occasional purgative, recumbency, and the use of cold water. Should the veins be accidentally ruptured, and the hemorrhage become serious, the bleeding vessels must be sought for, and ligated or acupressed.

Cavernous Angioma or Nævus of the vulva is by no means of unfrequent occurrence. I have met with it several times as a congenital affection, but it may also arise later in

life, chiefly as a venous growth, of a bluish color, and soft consistence, varying in size from a filbert up to that of a hen's egg. Occasionally it has a lobulated appearance, as in a case which came under my observation a few years ago. When the tumor is of large bulk, the best plan is to strangulate it with the ligature. The knife or *écraseur* may be used when it is pendulous with a narrow neck, and devoid of arterial matter.

Occlusion of the vulva, dependent upon adhesions of the labia, or the labia and nymphæ, is not uncommon. The occurrence is sometimes observed in very young children, occasionally, indeed, in infants at the breast, and is, of course, always the result of inflammation, not unfrequently caused by want of cleanliness, or the accidents of parturition. When the adhesion is slight, it is easily broken up with the probe or finger; when, however, it is extensive, the knife may be required, used prudently, lest more be divided than is proper.

Epithelioma of the labia is witnessed in females of middle age and advanced years. Commencing usually as a warty excrescence or a fissure, it exhibits the same characters, symptoms, and progress as carcinoma of other muco-cutaneous surfaces. The pain is sharp, pungent, and lancinating, the discharge is exceedingly fetid, the edges are undermined, the surface is tuberculated, with a tendency to hemorrhage, and the inguinal lymphatic glands are early involved. The treatment is conducted on general principles, early and free excision being indicated when the disease has not made too great progress, simply with a view to palliation, as recurrence is usually inevitable.

Finally, the labia are liable to various kinds of *tumors*, as the fibrous, cystic, fatty, myxomatous, and sebaceous, as well as to scirrhus, encephaloid, and sarcoma.

The *fibrous tumor* does not always originate in the labium, but may take its rise deep in the pelvis, and, advancing outwardly, involve the vulva secondarily. It is most common in young married females, and is capable of acquiring a large bulk, especially in the tropics, where it is much more frequent than in this country. Its shape is usually somewhat pyriform, its attachment being by a small base which often extends to a considerable depth. It is of a firm, slightly elastic consistence, movable, free from pain and discoloration, and little disposed to ulceration, the principal inconvenience being caused by its weight and bulk. As it enlarges, it gradually distends the labium, elongating it and dragging it down between the thighs. Dr. William J. Holt, of Montgomery, Alabama, has communicated to me the particulars of a case in which a growth of this kind measured twenty-three inches in circumference.

A section of the tumor displays a dense, firm, glistening tissue, not unfrequently interspersed with small cavities, resembling cysts, filled with a clear, serous, gelatinous, or sanguinolent fluid, sometimes spontaneously coagulable. The older growths of this description occasionally contain nodules of cartilage, or small earthy concretions, similar to those found in fibrous formations of the uterus.

The fibrous growth of the labium, notwithstanding it sometimes attains a great bulk, possesses little vascularity; its production is occasionally traceable to the effects of external injury, and it now and then, as in a case which I attended along with the late Dr. McWhinney, presents a distinct fibro-serous envelop.

The only remedy for the cure of this tumor is excision. In some instances the whole mass may readily be got rid of by enucleation. When the growth is prolonged into the pelvis, the pedicle, after suitable exposure, should be included in a ligature. The operation is seldom attended with much hemorrhage.

Cystic tumors, filled with serous, glairy, or dark-colored fluid, and of a spherical, ovoidal, or pyriform shape, are occasionally met with in the labia; they are generally unilocular, semitransparent, circumscribed, more or less fluctuating, and firmer than cedema, but not so hard as fibrous tumors. They may be caused by external injury, and, if unmolested, may ultimately attain a bulk equal to that of an infant's head. The treatment is by iodine injections, seton, or, what is better, excision.

The *fatty and myxomatous tumors* of the labium are uncommon; they are of slow growth, soft and doughy in consistence, and seldom attain much bulk. Occasionally they present a nodulated appearance, as if they were composed of several distinct masses. They require the same treatment as similar formations in other parts of the body.

Dr. G. B. A. Hanuschke has recorded a case of fatty tumor in the labium of a woman thirty-six years of age, that weighed nearly twelve pounds. It formed an

immense pendulous mass, of a pyriform shape, with a large pedicle firmly attached to the branches of the ischium and pubes. The operation, although very bloody, was perfectly successful.

The *sebaceous tumor* of the labia is also very rare. It is generally of a globular form, perfectly movable, free from pain, firm, but semielastic, and from the volume of a hazelnut to that of a pullet's egg. The treatment is by excision.

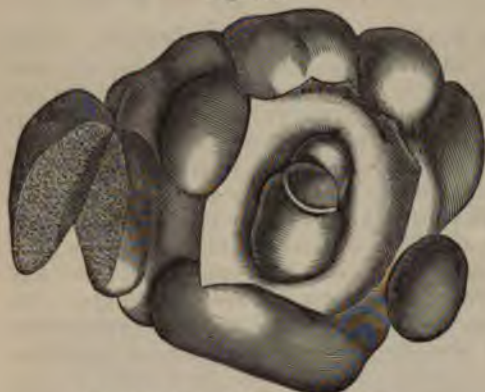
Scirrhus and encephaloid of the labia may occur as primary affections, but more frequently they extend to these structures, from the clitoris and the nymphæ; in some cases they are evidently offsprings of carcinoma of the uterus and vagina. The two diseases are characterized by the same phenomena as scirrhus and encephaloid in other organs, and demand the same treatment, the only reliable remedy being early extirpation.

In a case under my care, of primary scirrhus of the left labium of a woman forty-six years of age, removal was followed in four months by a return of the disease in the superficial and deep inguinal, iliac, lumbar, and anterior mediastinal glands, together with the liver, which, after death, eight months subsequently, weighed fourteen pounds. The secondary deposits were of an encephaloid character.

Sarcomatous or fibro-plastic tumors occasionally occur in the labia, where they may attain large dimensions. They present the same general features as sarcomatous

formations elsewhere, and do not require special description.

2. *Nymphæ*.—The nymphæ are not often the subjects of disease, independently of that of the great lips. They are occasionally the seat of hypertrophy or chronic enlargement, so excessive as to require excision, of encysted tumors, and of epithelial and encephaloid carcinoma. Of the latter disease, I met with an extraordinary case, in 1842, in a little girl, five years of age, who died, exhausted, at the end of nine months from the first appearance of the tumor. The morbid growth, as seen in fig. 677, had extensively involved the lymphatic glands of the groin and pelvis. The clitoris was also greatly enlarged.



Encephaloid of the Nymphæ and Clitoris.

A *cystic tumor*, filled with serum, sometimes occurs in the nymphæ; generally in married females, from the twenty-fifth to the fortieth year. It is soft, fluctuating, of a rounded or ovoidal form, and of variable dimensions, from an almond to that of an orange. The diagnosis is easily established by the exploring needle. The most effectual remedy is excision, but a cure may also be effected by the seton and by iodine injections.

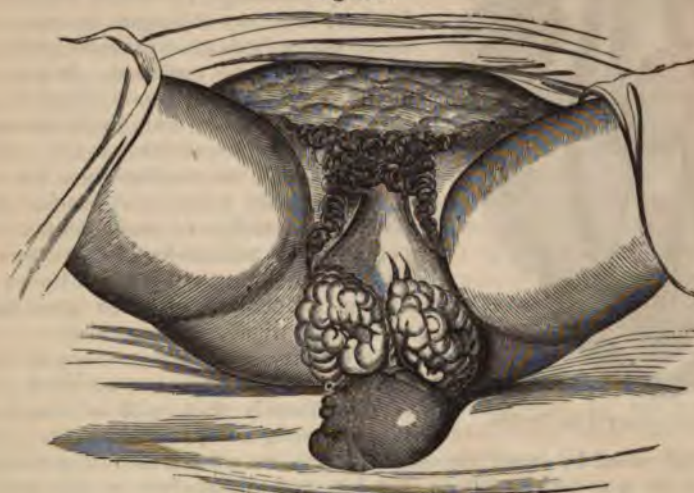
There is a form of cystic tumor of the nymphæ which is occupied by a thick, glairy mucous fluid, and which is evidently occasioned by the closure of the duct of the gland of Bartholine with retention of its natural secretion, which is sometimes excessively fetid. It is similar to the tumor sometimes found on the lip, and requires similar treatment.

A *polyp* occasionally grows from the nymphæ, as in a case under my notice in 1862, in a little girl only eight years of age. The tumor was of a scarlet color, granulated and fissured on the surface, destitute of sensibility, fibroid in structure, and about the size of a large hickory-nut. It adhered to the outer surface of the nymphæ by a short, narrow pedicle, and completely closed the orifice of the vulva. It had been first observed about one year previously. Removal was readily effected by ligation.

3. *Clitoris*.—The principal affection of the clitoris is hypertrophy, which may be so great as to be a serious inconvenience and annoyance. In some countries this organ is naturally much larger than in America and Europe. In Persia, Turkey, and Egypt, hypertrophy of the clitoris is often immense, the tumor thus formed perhaps equalling the size of an adult's head. The disease, which is sometimes congenital, is generally caused by protracted irritation. Courtesans were formerly sup-

posed to be particularly liable to attacks of this kind, but the researches of Parent-Duchatelet and others have shown that this is not the fact. The annexed cut, fig. 678, affords a good idea of this affection. The growth was associated with hypertrophy of the nymphæ. When the tumor has acquired a large bulk, the only remedy

Fig. 678.



Hypertrophy of the Clitoris and Nymphæ.

is excision. The operation is usually attended with a good deal of hemorrhage. When the disease is in its infancy, repression may be attempted with cooling and astringent lotions, tincture of iodine, and other sorbefacient means.

Clitoridectomy may be required on account of excessive enlargement of the clitoris, the presence of malignant disease, or epilepsy dependent upon the practice of masturbation. For the relief of the latter affection the operation has of late years been performed with very happy results in a considerable number of cases. Professor White, of Buffalo, recently reported three instances of this kind, in two of which the operation seemed to have been perfectly successful. Excision of the clitoris is sufficiently easy; but the hemorrhage is often very profuse, and is generally most readily and effectually controlled by acupressure. Professor White has suggested the substitution of the subcutaneous division of the pubic nerves for the more offensive mutilation of clitoridectomy.

The clitoris has occasionally been removed on account of erotomania, even when it was not materially enlarged. Such an operation is on a par with the amputation of the penis for the cure of onanism. Nothing could be more absurd.

A case of *wound* of the clitoris, followed by fatal hemorrhage within an hour after its occurrence, has been reported by Mr. Gutteridge, in the London Lancet for October, 1846. The accident was caused by a kick. The wound, situated at the entrance of the vagina, along the ramus of the pubes, was one inch in length by three-quarters of an inch in depth, and completely exposed the left crus of the clitoris, the cavernous structure of which was thoroughly crushed.

4. *Urethra*.—The female urethra is rarely diseased. The principal lesions to which it is liable are, stricture, vascular excrescences, dilatation, and prolapse.

a. *Stricture* is usually situated at the extremity of the tube, and may be so great as to produce much difficulty in making water. In some congenital malformations, the orifice of the urethra opens into the vagina at some distance from the external aperture. Occasionally, as when the mouth of the vagina is closed by a dense membrane, the urethra is so much dilated as to admit the male organ. These various affections must be met on general principles.

b. *Vascular, papillary excrescences* or polyps sometimes spring from the female urethra, or are seated around its orifice, as shown in fig. 679. They are of a bright scarlet color, exquisitely sensitive under pressure, and of a soft, spongy, erectile structure, with a smooth, fissured, or granulated surface. Their shape is generally pear-like, and in size they vary from a small pea to that of a horse-bean. The

Fig. 679.



Vascular Excrescences of the Urethra.

disease has been observed in young girls under seventeen, but is most common in adults. Its causes are unknown. The proper remedy is excision, followed by the gentle application of chromic acid.

Many years ago I assisted Professor Willard Parker, then my colleague, in removing a papillary polyp from the entrance of the urethra of a young lady of eighteen. It was of conical shape, nearly an inch and a half in length by three-quarters of an inch in diameter, very sensitive, of a bright, florid color, elastic and compressible. On maceration for a few days, it became perfectly white, and seemed to be composed essentially of soft connective tissue, pervaded by numerous bloodvessels. Several similar cases have since fallen under my observation. Removal of such growths may be effected by ligature or excision.

c. *Varicosity* of the vessels of the spongy tissue or of the veins surrounding the urethra is occasionally met with in the form of an ovoidal, soft, compressible tumor, the surface

of which is pervaded by small vessels. It may attain the size of a walnut, and is characterized by a sense of fullness, tension, and discomfort in the erect posture, which disappears during recumbency, pain in coition, and frequent desire to micturate. Strangulation, or the application of nitric acid, as in the treatment of hemorrhoids, is the proper remedy.

d. *Prolapse* of the urethra is chiefly met with in children from two to twelve years of age, in consequence of repeated and long continued efforts at straining. It is characterized by the existence of a small, soft, rose-colored tumor, in the centre of which there is an opening easily admitting a catheter. It often remains stationary for a long time, but may eventually acquire the bulk of a small hickory-nut, and be the seat of considerable pain, as well as of muco-purulent discharge. The tumor is liable to be confounded with a polyp in this situation; but from this it may readily be distinguished by its non-pedunculated appearance, and by the fact that it forms a distinct ring around the orifice of the urethra. The only remedy is excision or inclusion in a double ligature, the latter procedure being particularly indicated when there is danger of hemorrhage, as when the tumor is unusually large.

e. When the urethra is greatly dilated and the bladder relaxed and weakened, *inversion and prolapse of the bladder* may occur under two distinct varieties of form, the complete and the incomplete; the first consisting in an inversion of all the tunics of the bladder, while, in the second, the inversion is limited exclusively to the mucous membrane. The exciting cause is violent and frequent straining, such as accompanies various impediments to the evacuation of the urine and feces. Severe coughing may be mentioned as a predisponent.

In the treatment of the incomplete form of inversion and prolapse, the circumstances mainly to be attended to are, first, to enjoin strict recumbency for a long time; secondly, to reduce the tumor carefully, and to counteract afterwards any tendency to protrusion by the frequent use of the catheter, and astringent washes and injections; and, thirdly, to correct the general health by chalybeate tonics and other means. The bowels should be maintained in a soluble condition, and the urine should be passed in the recumbent posture, the patient lying on her side or back. Excision of the protruded part should be studiously avoided, as it might lead to fatal results.

Of the *complete* variety of inversion and prolapse of the bladder, very little is known. The most important signs, in a diagnostic point of view, are, the gradual development of the tumor, its soft and fluctuating feel, and the peculiarity of its situation. When we add to these circumstances the fact that there are usually three distinct apertures on the surface of the tumor corresponding with those of the urethra and ureters; that the tumor is easily reduced by pressure; that the patient is unable to retain her urine; that the part is not particularly tender, sore, or painful; and

that there is not, at least not necessarily, any derangement of the general health, the practitioner can hardly fail to detect the true nature of the malady.

In the reduction of the tumor, the patient is placed upon her back, the head and shoulders are elevated, and the thighs, flexed upon the pelvis, are widely separated from each other. The labia are then held apart by an assistant, while the surgeon applies his fingers, previously oiled, to the surface of the tumor, and pushes up that part which came down last, the pressure being maintained steadily, but gently, until the whole of it has slipped up behind the pubic symphysis. When the swelling is bulky, and of long standing, it may be necessary to assist these efforts by means of a catheter, applied to the fundus of the bladder, and carried up in the direction of the urethra. If the tumor has become irreducible, an attempt should be made to diminish its volume and hardness by leeches, fomentations, and other relaxing measures. Chloroform is a valuable adjuvant during replacement.

When the parts are restored, the patient should observe the recumbent posture, the urine should be drawn off frequently, and, if the protrusion be considerable, a compress, confined by a T-bandage, should be worn upon the mouth of the urethra. When the patient gets up, she should wear an abdominal supporter.

When the urethra is much dilated, an operation may become necessary. The inferior portion of the tube may be divested of its mucous membrane, after which the raw surfaces are approximated by a few points of interrupted suture, care being taken to draw off the urine several times a day, until consolidation is effected.

f. Retention of urine in the female may be caused: 1st, by the presence of a foreign body, as a calculus, or various substances introduced from without; 2dly, by spasm, as from cold, strangury, or stimulating medicine, food, or drink; 3dly, by organic stricture of the urethra; 4thly, by contusion and swelling of the urethra, as after external injury and the use of the forceps; 5thly, by paralysis of the bladder; 6thly, by mechanical pressure upon the neck of the bladder or urethra, as in pregnancy, in ovarian disease, in distention of the rectum, in pelvic tumors, and in prolapse, anteversion, retroversion, or lateral displacement of the uterus; and, lastly, by hysterical conditions of the mind, in which the bladder retains its power but cannot be influenced by the will. The manner of meeting these various contingencies is fully pointed out in a previous chapter.

In the retention of urine, consequent upon protracted labor, or copious flooding, the patient will frequently not be able to pass a drop of water, so long as she remains in the supine posture; but the difficulty at once vanishes if she gets on her side, raises her head and shoulders, or turns on her knees and elbows.

g. Catheterism must be performed with great delicacy under cover of the clothes, while the patient lies upon her back, near the edge of the bed. Ocular inspection can only be justifiable when the parts are in a state of great disease, or when the tube has undergone much change in its relative position. The best mode of proceeding is to apply the left index-finger to the upper margin of the mouth of the vagina, which thus serves as a guide to the instrument, which is placed upon its palmar surface, and then moved upwards along the middle line, until its point arrives at the dimple-shaped depression marking the situation of the orifice of the urethra. The catheter is then passed on, with its concavity upwards, until it reaches the interior of the bladder. Or, the instrument may be held against the under surface of the right index-finger, as in fig. 680, and pushed on as soon as its tip has discovered the meatus.

During parturition the orifice of the urethra is sometimes drawn backwards under the arch of the pubes, and in prolapse of the uterus it is occasionally concealed by the tumor. The canal may be changed in its direction, and the bladder itself may be dragged down into the protruded parts, so that, as was long ago observed by Verdier, in passing a catheter it must be directed downwards and backwards. Retention, after parturition, may be due to two causes—contusion of the urethra and atony of the bladder—both requiring the use of the catheter.

The female catheter is made of silver, and is not more than five inches in length.



Method of some Surgeons of Holding the Female Catheter.

Its vesical extremity is somewhat bent, to adapt it to the shape of the urethra, and is perforated with numerous foramina, instead of having eyelets, as that of the male. The other end is provided with two rings, in order to fasten the instrument, when it is necessary to retain it in the bladder, by means of tapes, to a T-bandage. When the urethra has been materially changed in its direction, the most suitable instrument will be a gum catheter or the ordinary silver male catheter.

It has long been known that the female catheter will occasionally slip into the bladder, being suddenly and unexpectedly drawn from the fingers of the surgeon. It is not very easy to explain the reason of this occurrence. It is probably owing to the contractile power of the urethra, aided by capillary attraction, and by the suction of the bladder.

Although the female catheter is generally more easily withdrawn than introduced, yet occasionally the reverse is the case. The occurrence is favored by a relaxed condition of the parts, and appears to be directly dependent upon the intromission of a fold of mucous membrane into the eyelets of the instrument. To avoid this contingency, as awkward as it is painful, the instrument should be provided with numerous small apertures, which will effectually prevent the intrusion of the lining membrane, however flabby. The proper remedy is the retention of the catheter until the accumulating urine forces the impacted folds into their natural situation. In case of urgency relief may be afforded by throwing a full stream of water into the instrument. All attempts at forcible extraction should be avoided.

There is occasionally a collection of serum in the groin, or in the groin and labium, constituting a species of *hydrocele*, either congenital or acquired. It is situated in the peritoneal sheath of the round ligament, known as the canal of Nuck, contains a thin, watery fluid, and forms a soft, elastic, fluctuating swelling, which sometimes communicates with the abdomen. It is of an elongated, globular, or pyriform shape, and ranges in volume between an egg and a fist. In a case observed by Scarpa, the cyst, attached by a narrow footstalk, was fourteen inches in circumference, and contained nearly a pint and a half of fluid. The tumor receives no impulse on coughing or straining, and is generally more or less opaque, although in rare cases it is translucent under transmitted light. The diagnosis is readily established by the history of the case and by the use of the exploring needle. A cure may be effected by incision, by seton, or by injection. Dr. Charles A. Hart has reported a case in which a growth of this kind was laid open under the belief that it was a strangulated hernia.

A serous tumor occasionally forms here in the sac of an old hernia, the neck of which has been obliterated by the pressure of a truss or by inflammation induced by some other cause. Such an occurrence is, of course, very uncommon, but its possibility is well attested, and is worthy of remembrance in connection with the diagnosis of the various affections liable to arise in this particular region of the body.

SECT. VII.—GONORRHOEA IN THE FEMALE.

Gonorrhœa in women is a very different affection from gonorrhœa in males; in the latter, the disease is generally exclusively confined to the urethra, or it exists simultaneously in this canal and on the head of the penis. In the female, on the contrary, it usually expends its force upon the lining membrane of the vulva, vagina, and uterus, the urethra being seldom implicated to any considerable extent, if, indeed, at all. Of 250 patients in the Aberdeen Royal Infirmary, only 9, according to Pirrie, had this canal affected. The parts which are generally most violently inflamed are the mucous follicles around the urinary meatus, and the upper portion of the vagina. Occasionally the disease extends to the cavity of the uterus, and thence, there is reason to believe, along the Fallopian tubes and ovaries, the attack thus presenting an analogy with gonorrhœa in the male, eventuating in epididymitis. The interior of the uterus is most liable to become affected in those females in whom that organ has an uncommonly large mouth, thereby allowing the more easy entanglement and retention of the gonorrhœal virus. The occurrence is, however, under any circumstances, unusual. The time which elapses between the contamination and the outburst of the disease is generally somewhat shorter than in men, owing to the fact that the poison is brought in contact with a larger surface. The disease may be simple or complicated; it is more frequently associated with chancre than in

the male, and is often followed by excoriations and simple ulcers, especially of the neck of the uterus and of the lower extremity of the vagina.

The symptoms of the disease are essentially similar to those which characterize gonorrhœa in the male. The parts, at first the seat of itching and smarting, soon become hot, swollen, painful, and affected with muco-purulent discharge, often bloody, usually excessively profuse, and, at times, very fetid and even acrid. The scalding in micturition is considerable, although rarely as great as in the male, and the labia, nymphæ, vagina, and the neck of the uterus, are frequently covered with aphthæ, fissures, and excoriations. In the more severe forms of the disease, there is a sense of weight and of fullness in the lower part of the pelvis, with aching pains in the groin, thigh, and perineum. The lining membrane of these parts is of a fiery red color, and covered, here and there, with patches of lymph, of a pale yellowish hue, tough and stringy, and firmly adherent to the surface beneath. During the progress of the attack, the lymphatic glands in the groin are liable to suffer, although much less frequently than in the male, becoming sore, and swollen; and so much distress is often experienced in walking as to compel the woman to keep her bed. Occasionally the inflamed surface, instead of being bathed with pus and mucus, is remarkably dry, and the suffering is then often proportionately much greater. Such an occurrence, however, seldom lasts beyond twenty-four hours, when it is generally followed by an abundant secretion.

In uterine gonorrhœa, the most common symptoms are, unnatural discoloration, and a discharge of thick, opaque mucus, filling up the mouth of the womb, or hanging from this organ into the vagina, and so tough as to be detached with considerable difficulty. Superficial ulceration is also a sufficiently frequent attendant upon this form of the disease.

From the recent observations of Mr. G. F. Giles, of London, it appears highly probable that gonorrhœa is occasionally productive of peritonitis, from an extension of the disease along the Fallopian tubes. The occurrence, believed to be most common in prostitutes, is characterized by the usual symptoms.

The diagnosis of gonorrhœa from other affections, especially leucorrhœa, although most desirable, is frequently very difficult, and sometimes altogether impossible. The distinction is particularly important on account of its medico-legal relations, females laboring under discharge of the genital organs being often suspected of having gonorrhœa, when, in fact, the disease is only of an ordinary nature. In general, the difficulty may be solved by the history of the case, the moral character of the woman, the nature of the discharge, and the presence or absence of complications. In leucorrhœa, with which the disease is most liable to be confounded, there is seldom any discharge from the urethra, or scalding and smarting in micturition; in gonorrhœa, on the contrary, these two symptoms usually exist in a very marked degree. In leucorrhœa, the disease is mostly confined to the vagina and uterus; the discoloration, although considerable, is seldom either great or uniform, and the vulvo-uterine canal is usually free from ulceration. In gonorrhœa the inflammation always involves the labia and nymphæ; the redness is of a fiery hue, and extensively diffused, the parts having almost an erysipelatous aspect, and marked abrasions, excoriations, or superficial ulcers are nearly constantly found upon the neck of the uterus, as well as upon the vagina. Finally, in leucorrhœa the pain is comparatively slight, and there is no disease of the lymphatic glands of the groin, the reverse being the case in gonorrhœa.

In attempting to form an accurate diagnosis of these diseases, too much caution cannot be exercised, otherwise there will be great danger of occasionally involving the innocent. A thorough examination should always be made with the speculum, not once, but repeatedly, and the moral character of the woman duly considered. If the patient is very young, or of an age when there are usually no sexual propensities, it may be presumed that the discharge is the result purely of simple vaginitis, want of cleanliness, the presence of worms in the lower bowel, derangement of the digestive apparatus, or an anemic state of the system. All vaginal discharges are acrid, and intermixed with abraded epithelium; but neither the microscope, nor any chemical test at present known, is of any avail in determining whether they are of an ordinary or of a contagious character.

The treatment of gonorrhœa in the female must, unless there be some special contra-indication, be by active depletion until there is a marked diminution of the discharge and local distress, when trial may be made of copaiba, or copaiba and

cubebs, although, as the disease is rather a vulvo-vaginitis than a urethritis, these articles generally exert very little, if any, specific influence in controlling the morbid action. The patient is confined to bed, and, if plethoric, freely bled at the arm, especially if the inflammation run very high, as denoted by the severity of the pain, and the sense of weight and fullness in the pelvic region, together with the profuseness of the profluvia. The venesection should be followed up by a brisk cathartic of the compound calomel pill, or an infusion of senna and sulphate of magnesia; and this, in turn, by antimonial and saline preparations, given every three or four hours, according to the exigencies of the case. The diet must be light, simple, and duly restricted in quantity.

If the local action is unusually high, leeches are freely applied to the groins, the vulva, and the inside of the thighs. The vagina is frequently sponged with tepid water, impregnated with some mildly astringent substance, as alum or sugar of lead; or, if the discharges are offensive, with permanganate of potassa, care being taken that the injections, whatever they may be, are not so strong as to cause pain. When the inflammation has been somewhat moderated, the opposed surfaces should be kept constantly asunder by means of a plug of patent lint, wet with a strong solution of Goulard's extract, substitution being effected not less than three or four times in the twenty-four hours. In this way the treatment may generally be very materially abridged. Dr. John S. Black has found great benefit in the treatment of vaginitis from the use of suppositories of alum and tannic acid, subsulphate of iron, and kindred articles.

When the inflammation has reached the subacute or chronic state, the lotion may be dispensed with, and the tent smeared with ointment of nitrate of mercury diluted with ten parts of simple cerate. Under the influence of this application all discharge generally ceases in a few days. When ulcers exist upon the neck of the uterus, or upon the vulvo-vaginal mucous membrane, they should be gently touched every third or fourth day with the solid nitrate of silver, or, what is preferable, with very dilute acid nitrate of mercury. The same rule in regard to the continuance of the treatment, after all discharge has been arrested, should be observed here as in gonorrhœa of the male. The exhibition of copaiba and cubebs is chiefly indicated when the urethra is much implicated; for, as already intimated, the peculiar antigonorrhœal virtues of these articles do not display themselves at all when the disease is confined to the vulva, vagina, and uterus.

In uterine gonorrhœa, the proper plan is to detach the glairy mucus so liable to form in this complaint, several times a day, by means of a mop, or mop and forceps, and to cauterize the canal of the neck of the womb, very gently, every forty-eight hours, with solid nitrate of silver. Injections of this substance, however weak, cannot be employed with safety, on account of their liability to enter the Fallopian tubes, and to occasion violent, if not fatal, peritonitis. In gonorrhœal peritonitis the ordinary remedies will be required, especially leeches and fomentations to the abdomen, and full doses of opium. The abstraction of blood from the uterus and vulva will also be very serviceable.

Abscesses are very liable to form in the labium, in the more severe forms of gonorrhœa, and should always claim early attention, as they are generally excessively painful, and may, if neglected, occasion serious structural lesion. Their contents are usually excessively fetid, and of a thick, purulent character. The nymphæ sometimes suffer in a similar manner.

Buboes, arising during the course of the disease, are treated by rest, leeches, iodine, acetate of lead, and anodyne cataplasms. Matter is evacuated by an early and free incision. If the resulting ulcers and sinuses are long in healing, the knife and caustic must be used.

SECT. VIII.—VESICO-VAGINAL FISTULES.

The bladder of the female is liable to various kinds of fistules, deriving their names from the organs with which they communicate, as vesico-vaginal, urethro-vaginal, vesico-uterine, vesico-utero-vaginal, and vesico-rectal.

The most common cause of this affection is the accidental laceration of the parts during parturition, in consequence of the pressure of the child's head, especially if the accoucheur has neglected to empty the bladder. It may also be produced by the maladroit use of the instruments, inducing either direct rupture, or such an amount

of contusion as to eventuate in gangrene and sloughing; by penetrating wounds of the vagina and bladder; and by ulceration, whether occasioned by abscess, simple, syphilitic, or malignant disease, or by the pressure of a urinary calculus, a pessary, or any other foreign body.

A great deal of diversity obtains in regard to the size, shape, and number of vesical fistules. Thus, the opening may not exceed the diameter of a small shot, or it may be so large as to admit a pullet's egg, or even a small orange. In its shape it is generally somewhat oval or circular, but occasionally it presents itself in the form of a transverse, oblique, or longitudinal rent, slit, or fissure. Its edges are usually well defined, rough, callous, and white, with a slight eversion of the vesical mucous membrane. The induration often extends a considerable distance beyond the fissure, especially when this has been caused by sloughing, and it is, therefore, occasionally very difficult to pare the edges of such an opening. The vagina in the neighborhood of the aperture is either perfectly sound or variously altered by disease, according to the nature of the exciting cause of the fistule, the violence of the resulting inflammation, and the acrid character of the discharges. It is not often that there is more than one opening.

A singular eversion of the bladder occasionally takes place in vesico-vaginal fistule, the lining membrane passing across the abnormal aperture so as to form a tumor in the vagina. The protrusion, which is seldom considerable, is generally of so trifling a nature as not to require any special attention. When, however, the artificial opening is unusually large, the whole bladder may project through it, and eventually even protrude at the vulva, as in the remarkable case mentioned in my Treatise on the Urinary Organs.

A woman affected with vesico-vaginal fistule must necessarily be an object of the deepest commiseration. Incapable of controlling the contents of the bladder, the urine constantly escapes at the vagina, thus not only soiling her clothes, and giving rise to the most noisome odors, which no amount of cleanliness can entirely prevent, but chafing and fretting the parts with which it comes in contact, and thus rendering them unfit for the exercise of their appropriate functions. The escape of fluid is incessant when the opening is situated at the bas-fond of the bladder, and is always worse in the erect than in the recumbent posture.

The existence of this affection is generally indicated by the escape of urine by the vagina; but the situation, shape, and extent of the fistule can only be ascertained by means of the speculum, the woman lying on her back, or, what is better, resting on her knees and fore-arms, with the head as dependent as possible, and the nates considerably elevated, a catheter being at the same time inserted into the urethra. In this way every portion of the vagina may be most satisfactorily inspected, and any opening, however small, easily detected. In some instances, the speculum is advantageously replaced by the finger, carried about in different directions, along the anterior wall of the tube, until its extremity comes in contact with the naked end of the catheter. When the aperture is very small, a long, slender probe should be used or a colored fluid may be thrown into the bladder with a syringe.

Treatment.—The treatment of this affection is palliative and radical; the former consisting in the employment of such means as are adapted to promote temporary comfort, while the latter are designed to effect the permanent obliteration of the abnormal opening. Frequent ablutions and injections with cold water, either simple or medicated, and the occasional use of chlorinated soda, will prevent excoriations and noisome fetor, and a proper regulation of the diet with a soluble condition of the bowels, will go far in preserving the general health, which, in such a condition, sometimes suffers most severely, the patient becoming nervous, dyspeptic, and hysterical. To guard against the incessant escape of the urine, and enable the poor patient to exercise occasionally in the open air, the vagina should be kept constantly filled with a hollow plug, or caoutchouc bottle, enveloped in oiled silk, and furnished with a tube and stop-cock, in order that it may be inflated or emptied at pleasure. Or, instead of this, a reservoir, such as that referred to at p. 752, may be suspended from the vulva.

The radical treatment of vesical fistule has been brought to a high degree of perfection, almost exclusively by the labors of two practitioners, Dr. Sims, and Dr. Bozeman, to the former of whom great credit is deservedly due for having led the way in this most laudable enterprise. Previously to this, occasional cures had

been effected by different American surgeons, especially by Hayward, Mettauer, and Pancoast.

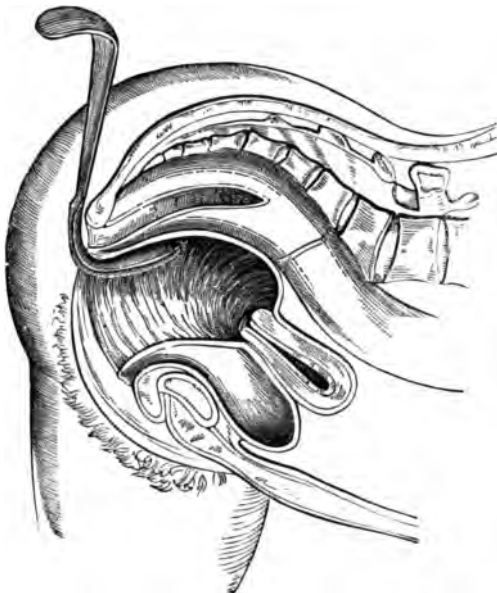
The operation of Dr. Sims was originally performed with silver wire, the ends of which were fastened with an ordinary shot, perforated at the centre. He accordingly called his suture the clamp-suture. For the shot Dr. Bozeman substituted a broad piece of sheet lead, generally of an oval shape, as seen in fig. 681, about a third of a line in thickness, pierced by several apertures, and variously bent in order to adapt it accurately to the shape of the parts. Dr. Sims has of late years altogether discarded the use of the clamp, and now confines himself to the employment of the wire suture. Dr. Bozeman, I believe, still operates with the aid of his button. I have myself effected excellent cures both with and without these aids, and am satisfied that the simple wire suture is, in the main, the very best that can be adopted. The button-suture may, however, be usefully employed in vesico-uterine and urethro-vaginal



fistules, as it serves to support the edges of the fissure and prevent undue traction. A certain amount of preliminary treatment is generally necessary, not protracted, but thorough, both as it respects the parts and the system at large. The most absolute recumbency and cleanliness should be observed; the vagina should be frequently syringed with cold water; cold cloths should be kept constantly upon the vulva; the bowels and secretions should be properly regulated; the diet should be perfectly plain and simple; and large quantities of bland drinks should be used to dilute the renal secretion, and deprive it of its acrimony. Blood should be taken from the arm, or from the vulva, perineum, groins, and thighs, by means of leeches, if there be evidence of decided plethora, and the parts, if much inflamed, should be gently touched, every other day, with solid nitrate of silver until the disease has measurably disappeared. Any contractions that may exist in the vagina must be carefully and thoroughly divided.

When the neck of the uterus is imprisoned in the bladder, an effort must be made to reinstate it in its natural situation, as well as to relieve it of inflammation, before attempting to close the fistule. For this purpose, the cervix is drawn down with a

Fig. 682.



Position of the Patient in the Operation for Vesico-Vaginal Fistula.

blunt hook while the fundus is dislodged from its position between the vagina and the rectum with a sponge mop, the woman resting upon her knees and arms, so as to bring the parts fully into view. When held in this way, a tent, such as that described on a previous page, is introduced, renewal being afterwards effected twice a day, preceded by injections of cold water, until the organ is disposed to maintain its place.

The patient, freed from all bodily constriction, and thoroughly influenced by chloroform, is placed upon her abdomen, across an ordinary bed, protected with oil cloth. The head and shoulders being depressed, the nates may be elevated to any desirable height, and the light so arranged as to fall directly upon the entire vesico-vaginal septum, the fistule, and the mouth of the uterus. The thighs are widely separated, and supported by assistants. The duck-bill speculum of Dr. Sims is now introduced, fig. 682 showing the application of the

instrument, the position of the nates, the appearance of the dilated vagina, and the situation of the uterus, bladder, and vesico-vaginal septum. If the light be insufficient, a small mirror may be used, the reflection of which will generally render

everything perfectly distinct, and enable the operator to proceed without any embarrassment from this cause.

The edges of the fistule are most thoroughly bevelled off at the expense of the vaginal mucous membrane, at the same time that the incision is carried freely through the muscular and mucous coats of the bladder, so as to form an ample surface for approximation and agglutination. It is impossible to lay too much stress upon the manner in which this part of the operation is performed. If the opening is circular, unusually large, or vertical, the edges should be sloped in such a way as to admit of being brought together transversely, otherwise complete union will be very difficult, if not impracticable. The instruments required for paring the fistule are, a delicate tenaculum, long, slender, toothed forceps, a straight and angular knife, and a pair of scissors, represented in figs. 683, 684, 685, 686, and 687. The scissors are provided with very short, sharp-pointed blades, slightly curved on the flat. The anterior border of the fistule is pared first, and this is done most easily with the straight knife, the necessary quantity of substance being excised in one piece. For refreshing the posterior margin, the curved knife or scissors will be found most convenient. When the opening is very large, this stage of the operation is sometimes impeded by the protrusion of the vesical mucous membrane, but the obstacle may usually be readily overcome by returning the part, and then filling the bladder temporarily with bits of sponge.

Fig. 683.

Fig. 684.

Fig. 685.

Fig. 686.

Fig. 687.

Fig. 688.



Instruments for Vesico-Vaginal Fistule.

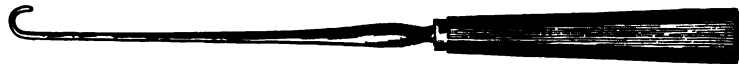
Needle-holder.

The next step of the operation consists in introducing the sutures, the number of which must necessarily vary according to the extent of the fistule. The instruments required for this purpose are several needles, a needle-holder, a pair of long, curved forceps, and a small hook.

The needles commonly employed in this operation are entirely too small and not sufficiently curved. They should be at least an inch and a half in length, stout, well tempered, moderately curved, like the ordinary suture instrument, and very sharp at the point. Unless they possess these qualities, the operation will be attended with great vexation and delay, and it will be found to be extremely difficult, if not impos-

sible, to take deep, firm, enduring stitches, a matter essential to success. The best needle-holder, at all events the one which generally answers the purpose very well in my hands, is the instrument sketched in fig. 688.

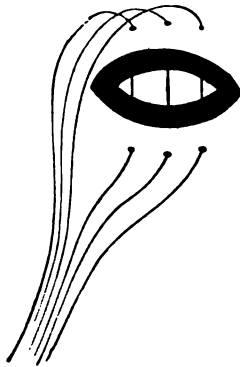
Fig. 689.



Hook for Making Counter-pressure.

The first suture should be introduced at the centre of the fistule, the distance at which the needle is entered from its anterior edge being not less than one-third of an inch, as the object is to obtain a very firm hold. The instrument, pushed steadily on, is brought out of the sub-mucous cellular substance of the bladder, counter-pressure being made against its advancing point with a pair of forceps, or the hook represented in fig. 689. The needle is then carried across the fissure, and entered at the posterior edge, which it traverses in a similar manner as the anterior. Thus suture after suture is introduced, until the number is completed, the interval between each two being about three-sixteenths of an inch, as exhibited in fig. 690.

Fig. 690.



Application of the Sutures.

The closure of the fistule, and the arrangement of the shot or button, constitute the third stage of the operation. This is easily done with the aid of an adjuster, represented in fig. 691. It consists of a strong rod, curved in the shaft, and set into a handle, its distal extremity being perforated and somewhat bulbous. The opposite ends of each wire are now passed through the opening in the instrument, and firmly held between the thumb and forefinger of the left hand, when the adjuster is carefully slipped down, and well pressed against the parts. Fig. 692 shows the appearance of the parts after all the sutures have been adjusted, and the edges of the opening approximated. The operation is finished by firmly twisting together the ends of the wires, and then cutting them off close to the fissure.

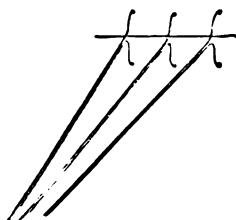
Fig. 691.



Suture-adjuster.

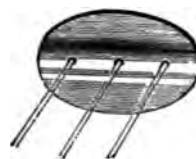
If the button is used, one of suitable shape and size is now selected, and passed over the wires, as seen in fig. 693; its concave surface corresponding to the vesico-vaginal septum, with which it is brought in close contact by means of the instru-

Fig. 692.



Adjustment of the Sutures.

Fig. 693.



Application of the Button.

ment represented in the annexed cut, fig. 694, the angular and scalloped extremity of which admirably adapts it for that object. The crotchet is now slipped down over the approximated ends of each suture, as illustrated in fig. 695, and pressed

firmly against the convex surface of the button by means of a pair of forceps, to keep the button in place, and the edges of the wound thoroughly united. Finally,

Fig. 694.



Instrument for securing the Button.

the operation is completed by clipping off the wires close to the crotchet, and turning down their short ends, as delineated in fig. 696.

Certain modifications of this operation are frequently necessary, growing out of the peculiar situation of the fistule, or the condition of the parts. Thus, as Dr.

Fig. 695.



Slipping down the Crotchets.

Fig. 696.



Suture Completely Adjusted.

Bozeman has so well pointed out, in the urethro-vaginal lesion, the button must be rather long in the antero-posterior direction, very concave, and extended well forward in front of the urinary meatus, so as to support the catheter, its extremity being somewhat notched. The edges of the opening are brought together transversely; and the catheter, a gum-elastic one, is introduced before the sutures are adjusted, retention being maintained, if possible, until the cure is completed.

In fistules involving the vesical trigone and the root of the urethra, or of the trigone and bas-fond, or of all these parts together, in which the anterior border of the opening is immovably fixed to the pubic arch, with the concavity presenting backwards, the button requires to be bent upon its convexity.

Considerable modification is required when the fistule extends into the neck of the uterus. The paring of the edges being effected in the usual manner, the button is carefully adapted to the shape of the parts, its posterior border being generally notched to accommodate the anterior lip of the cervix. A semicircular button is required when there has been so much loss of substance of the vesico-vaginal septum as to render it impossible to draw the anterior border of the fistule up to the posterior. The line of the perforations corresponds with the former border, while the notch in the button projects over the anterior lip of the neck of the uterus. Instead of using a button, the vivified edges may be approximated by the interrupted suture, as seen in fig. 697.

When the neck of the womb is lacerated, and buried in the bladder, the first thing to be done is to restore the organ to its normal position in the vagina, in order that, after the cure is completed, the menstrual fluid may resume its natural outlet. To effect this, it is necessary to enlarge the fistule in the vesico-vaginal septum on each side, transversely, thus disengaging the viscus somewhat, and affording more space for paring the anterior lip of the cervix. In inserting the sutures into the posterior border, the vesical mucous membrane is pierced by the needle, which, being carried into the bladder through the fistule, is entered far in on the vesical side of the cervix, and brought out from behind forwards, the object of the procedure being to obtain such a hold upon the womb as to enable the operator to pull its neck downwards and backwards during the adjustment of the sutures, restoration of the displaced organ being impracticable in any other way. The button for this variety of fistule requires to be bent upon its

Fig. 697.



The Cervix slit up to expose the Fistule above, with the Sutures in Position.

convexity, and to be notched above for the support of the anterior border of the neck of the uterus.

When the opening is uncommonly large, Dr. Simon, of Heidelberg, whose experience in the treatment of vesico-vaginal fistule is very extensive, employs a double suture, as he terms it, one to lessen the tension, and the other to unite the edges of the fistule, the threads in the latter being invariably carried through the mucous membrane of the bladder.

Fig. 698.



Sims's
Catheter.

During these various procedures, which must necessarily be more or less tedious and fatiguing, both to the patient and operator, great advantage will be derived from the use of several sponge mops, of various shapes and sizes, for wiping away the blood and secretions. The bleeding is usually insignificant, and readily stops of its own accord, or under the application of ice. The operation being over, a Sims's catheter, fig. 698, is inserted into the bladder, a gum-elastic tube, about fifteen inches in length, having previously been secured to its outer extremity, in order to conduct the urine into a large bottle lying in a hollow between the patient's thighs.

Dr. J. Goodman, of Louisville, Kentucky, lately devised a self-retaining catheter, the use of which, it is said, greatly facilitates the cure after this operation. It is about two inches in length, curved to the shape of the urethra, bulbous at the vesical extremity, and surrounded by a button nine lines in diameter. The instrument need not be cleaned oftener than once a week, and has the additional advantage of permitting the patient to sit up or walk about at pleasure. Excellent cures, as I can testify from personal observation, are occasionally effected without the aid of any catheter whatever, the passage of the urine being left solely to the natural efforts of the bladder.

After-treatment.—Much of the success of this operation, and, indeed, of every other of a similar kind, will depend upon the after-treatment. As soon as the patient is put to bed, a large anodyne is administered to allay pain and induce quiescence of the bowels, which should not, on any account, be disturbed under ten, twelve, or fifteen days. The diet should consist exclusively of animal broths, potato, bread, crackers, custard, rice, and tea, with water as the common drink. Opium is given twice a day in as large doses as can be borne; the urine is rendered bland and unirritant by the liberal use of diluents; and the patient is not permitted, even for a moment, for any purpose whatever, to assume the erect posture, although she may, if she prefer it, lie on either side. The catheter is removed as often as may be necessary to keep it clear of blood, mucus, and calculous matter, once a day generally sufficing. The vulva and orifice of the vagina are syringed night and morning with tepid water, a large bed-pan being placed under the nates during the operation. Undue inflammation is treated on general principles.

Both the part and the system are occasionally endangered, after this operation, by erysipelas. In a patient under my charge several years ago, although more than usual care had been bestowed upon the preliminary treatment, a most violent attack of this disease took place within a few days, commencing on the right buttock, and gradually spreading over the upper part of the thigh, perineum, and vulva, from which it speedily extended to the vagina, causing large deposits of lymph, with a strong tendency to cohesion. The constitution suffered very much, and at one time I was not without serious apprehension in regard to the ultimate issue of the case. Notwithstanding all this, however, the woman made a good recovery, although several months elapsed before she fully regained her strength.

Peritonitis has occasionally occurred after this operation, and it is well enough always to have an eye to the possibility of such an event; so that, if it arise, it may be promptly combated. It rarely appears before the third day, or after the sixth or eighth.

A case has been reported by Paul Horteloup, in which the accidental division of the left utero-ovarian artery, in paring the edges of the fistule, was followed by fatal hemorrhage. The flow was controlled for several days by a pair of screw-forceps, but its recurrence proved speedily disastrous.

The sutures should not, as a rule, be removed before the tenth day; if taken out sooner, the adhesions may give way, and thus necessitate a repetition of the operation. The patient being placed in the same posture as in the first instance, the wires

are clipped with a pair of curved scissors, and gently drawn away. Recumbency is observed for several days longer, and distention of the bladder is avoided until the new cicatrice is sufficiently strong to resist the pressure and traction of the surrounding parts. Any little apertures that may remain in the line of the sutures may usually be promptly closed with the aid of nitrate of silver.

When the operation fails, whether in whole or in part, as it not unfrequently does, even in the hands of the most skilful surgeon, further interference must be postponed until the parts and system have perfectly recovered, otherwise failure will again be inevitable. Of 186 cases of this operation reported by Bozeman, Brown, and Simon, ten died.

SECT. IX.—VESICO-RECTAL FISTULES.

Vesico-rectal fistules are generally caused by wounds, ulceration, abscess, or malignant disease. The characteristic sign is an interchange of the contents of the two contiguous reservoirs, the urine passing into the bowel, and the feces into the bladder. Owing to this circumstance, the parts are sore and irritable, and the general health is more or less disordered in consequence. Moreover, the constant introduction of fecal and other matter into the bladder is liable to give rise to calculous concretions, and to retention of urine.

The more simple forms of this affection often disappear of their own accord. In all cases the bowels should be maintained, for days together, in a perfectly quiescent state by morphia, opium, or laudanum, and the rectum should be washed out several times in the twenty-four hours with cold water, or, if the discharges are fetid, with a very weak solution of chlorinated soda. The recumbent posture should be carefully observed; the diet should be of the most bland and simple character; and drinks of every description should be used as sparingly as possible. As the case progresses, the closure of the fistule may often be greatly promoted by the constant retention of the catheter, which thus conducts off the urine as fast as it reaches the bladder, and, of course, prevents it from passing into the bowel.

If nature fails to accomplish her purpose, a cure may not unfrequently be effected by the use of nitrate of silver, acid nitrate of mercury, or the actual cautery, applied with the aid of an anal speculum. In very obstinate cases, especially when the abnormal opening is situated very low down, the edges may be pared, and united by suture, as in vesico-vaginal fistule. The anus should be widely dilated during the operation by means of blunt hooks. When this proceeding does not afford the requisite room, the best plan is to divide, as a preliminary step, the sphincter muscle.

One of the most remarkable cases of *vesico-vagino-rectal* fistule on record came under my observation in a woman, twenty-seven years of age, the accident having occurred during a protracted labor. For the first twelve months the urine dribbled off constantly by the anus; but, after that period, she was able to retain it for half an hour or even an hour at a time, especially when in the erect posture. The rectum, which thus served the purpose of an accessory reservoir for the urine, was unusually tender and irritable, while the anus constantly exhibited an inflamed and excoriated appearance. The orifice of the urethra was natural, but all attempts to pass an instrument, even the smallest pocket-probe, proved abortive. Menstruation was performed with great regularity, although rather sparingly, and the fluid, which was of the natural color, was discharged by the anus.

Finding it impossible to restore the vagina, I introduced a large curved trocar into the urethra, for the purpose of reëstablishing the natural channel for the urine. The operation was performed without difficulty, the woman being under the influence of chloroform, and a self-retaining catheter was immediately inserted into the bladder. By wearing this, off and on, for several weeks, the passage was completely restored to its former size, the urine being discharged only five or six times in the twenty-four hours, and then always in a full stream. She had, in fact, the most thorough control over the bladder, the general health was excellent, and not a drop of urine escaped by the anus. The menstrual fluid also passed off by the bladder.

SECT. X.—LACERATION OF THE PERINEUM.

Laceration of the perineum, usually a casualty of parturition, in consequence of the large size and rapid descent of the child's head, or the maladroit use of instru-

ments, occurs in various degrees, from the slightest division of the skin and mucous tissues, to the union of the vagina and rectum into one cavity. In the latter case, there is, of course, more or less involvement of the recto-vaginal septum, the rent, perhaps, reaching up from six to eighteen lines. Owing to the laceration of the sphincter muscles of the anus, an accident which always necessarily attends the worst forms of the lesion, the woman has seldom any control over her bowels.

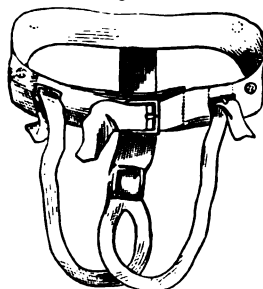
The treatment of this affection varies according to its extent and character. The more simple forms generally promptly get well spontaneously, especially if proper care be bestowed upon them soon after their occurrence, in the way of rest, thorough approximation of the limbs, and cleanliness, assisted by light diet and a confined state of the bowels. When the rent is extensive, the quilled suture must be employed, the stitches being introduced very deep, and retained until there is a certainty of complete adhesion of the opposed surfaces. A similar plan of treatment is adopted when the case has been neglected, but, in addition to this, it will be necessary, before arranging the ligatures, to see that the edges of the fistule are properly refreshed. This is usually easily done with the bistoury and forceps, aided with the scissors. The raw surfaces should not, on an average, be less than two inches in length by nine to twelve lines in width. The borders of the recto-vaginal septum are also well pared, and carefully united, as a preliminary step, two stitches always sufficing for the purpose. In sewing up the perineal portion of the fissure, at least three ligatures will be necessary, the first being inserted at the verge of the anus, and the last at the base of the labia, through their substance. The hold should be very firm, otherwise there will be danger of premature separation.

In performing the operation, the patient, brought fully under the influence of chloroform, is placed upon her back, as in the operation of lithotomy, the bowels having been thoroughly cleared out the night before. For sewing up the recto-vaginal septum the best instrument that I know of is the one represented at p. 540, in the section on staphylorrhaphy. The ligatures for the perineal fissure are readily introduced with the aid of a long needle in a fixed handle. The eyelet should be large, so that the thread may be easily reinserted above, after transfixion has been effected on the opposite side. The ends of the ligatures are then separated, and secured over two pieces of bougie, the superficial portions of the wound being brought together with a few points of the interrupted suture. If there be much tension, the operator may now divide the sphincter muscle of the anus, from an inch to an inch and a half exterior to this opening, the incision beginning about three lines in front of the coccyx, and extending some distance outwards and backwards, the gap being left to fill up by granulation. Such an expedient, however, will seldom be required, and I have not myself been obliged to resort to it in any of my cases.

The operation being over, the patient is placed in bed, her knees lying upon a pillow, and being tied together, to prevent any strain upon the perineum. Half a grain of morphia is at once given, in order to relieve pain and lock up the bowels, which should not be moved for at least ten or twelve days. The diet should be concentrated, and brandy freely used if there is evidence of debility. For the first three or four days, the parts are covered with cold water-dressing, and a syringe of cold

water is occasionally thrown into the vagina. The sutures are not disturbed, on an average, under a fortnight, or until there is reason to believe that the union is perfect. Strict recumbency is maintained for at least a week longer. The urine is drawn off twice a day.

Fig. 699.



Perineal Bandage.

PERINEAL BANDAGE.

The perineal bandage is a contrivance of great value for retaining dressings upon the vulva, perineum, and anus, as well as for affording support in prolapse of the uterus and rectum. It consists, as the adjoining cut, fig. 699, sufficiently indicates, of two distinct pieces, a circular and a perpendicular, the former passing round the hips, and the latter over the perineum and vulva, where it is provided with a pad, covered with oiled silk. It is then split in two, each strip being brought up in front, and attached to the circular girth.

provided with a pad, covered with oiled silk. It is then split in two, each strip being brought up in front, and attached to the circular girth.

SECT. XI.—RETRO-UTERINE HEMATOCELE.

A peculiar form of sanguineous tumor, first accurately described by Nélaton, is occasionally met with in the pelvis, the blood upon which it depends being poured out into the subperitoneal cellular substance of the neck of the uterus, from which it gravitates around the rectum and the upper extremity of the vagina, as shown in fig. 700. It usually takes place under the influence of inordinate straining during parturition, excessive sexual excitement, difficult menstruation, or external violence, and may acquire such a bulk as to break through its confines into the peritoneal cavity. Generally, however, it is comparatively small, and eventually disappears through the agency of the absorbents. The disease, which bears the strongest resemblance to a thrombus of the vulva, is most common in females laboring under a varicose condition of the utero-pelvic veins, habitual constipation of the bowels, and morbid growths of the uterus and its appendages interfering with the free return of the blood.

Fig. 700.



Retro-Uterine Hematocoele: *a* representing the Tumor; *b*, the Uterus; *c*, the Rectum; *d*, the Bladder.

The hemorrhage may proceed from different sources. Most commonly it is derived from the veins of the broad ligaments, or from the rupture of a Graafian vesicle during its extreme congestion at the menstrual period. It may also be caused by a reflux of blood from the uterus, as when the mouth of that organ is occluded by some obstruction; and cases have been recorded in which it emanated from injury of the Fallopian tube.

Age exerts an important influence upon its production. Of 34 cases analyzed by Voisin, 20 were between twenty and thirty years old. I am not aware that it has ever been observed before the age of puberty. Its favorite period is evidently that of the greatest sexual vigor.

The diagnosis is commonly obscure. The most reliable sign is the existence of a tumor at the sides and back of the neck of the womb, distinguishable by the finger in the vagina and rectum, free from pain, and the seat of more or less fluctuation, especially if the examination be made soon after the occurrence of the accident. The fundus of the uterus is generally tilted somewhat forward toward the pubes, while the neck of the organ is inclined proportionately backward, and sensibly diminished in length. The affections with which it is most liable to be confounded are, retroversion of the uterus, pelvic abscess, extra-uterine foetation, and dropsy of the ovary; but from these it may usually be readily distinguished by the history of the case, the median position of the tumor, and the suddenness of the attack.

The treatment of retro-uterine hematocoele is generally very simple; for, unless the tumor is of unusual bulk, it commonly soon disappears spontaneously, particularly if the woman be kept at rest in the recumbent posture, and upon light diet. If symptoms of inflammation arise, as indicated by pelvic pains and constitutional disturbance, leeches, fomentations, purgatives, and other antiphlogistics will be required. The sudden disappearance of the tumor, followed by great tenderness in the hypogastrium and depression of the vital powers, should lead to the suspicion of its rupture and the escape of its contents into the peritoneal cavity.

When the case is obstinate, refusing to yield to ordinary measures, the best plan is to evacuate the tumor with a large trocar, carried through the rectum or vagina, the sac being well washed out immediately after with tepid water, lest suppuration

should occur. The canula, which should generally be withdrawn on the completion of the operation, may occasionally be advantageously used for breaking up the clotted blood, so as to promote its more easy escape. It is proper to add that puncture of a hemocele has occasionally been followed by serious hemorrhage, pyemia, and other bad results.

SECT. XII.—PELVIC CELLULITIS.

The cellular substance of the pelvis, the broad ligaments of the uterus, and the recto-vaginal cul-de-sac is liable to inflammation, known as pelvic cellulitis. The phrase "pelvic abscess" is also very generally employed, as the inflammation not unfrequently terminates in suppuration. The disease, which is of a phlegmonous character, often involves the uterine appendages, is not confined to any particular period of life, occurs both in single and in married females, although much more frequently in the latter than in the former, and is produced by a great variety of causes, among which the most common are external injury, as a blow, kick, or fall, and violence inflicted by the passage of the child's head in difficult labor. It may also be caused by excessive sexual intercourse, by suppression of the cutaneous perspiration, and by an extension of inflammation from the uterus, vagina, vulva, bladder, or rectum. The most common seat of the disease is the cellular substance of the pelvis. Lying-in females are its most frequent subjects. Of 61 cases observed by Dr. M'Clintock, of Dublin, nearly one-half occurred after the first labor.

The disease is generally ushered in by bold and well-marked symptoms. The pain, at first dull and heavy, soon assumes a violent, throbbing, pulsatile character, and is always increased by motion and pressure; it generally begins low down in the pelvis, but as the disease proceeds it radiates about in different directions, and is often very severe in the iliac, supra-pubic, and anal regions. The whole hypogastrium is sometimes exquisitely tender. Gradually swelling sets in, easily detectable by the finger in the vagina and rectum, hard at first, but soft and fluctuating if the disease has made considerable progress. If the quantity of matter, upon which its presence mainly depends, is at all large, the tumor may encroach sufficiently upon the vagina, uterus, and rectum to occasion serious displacement or obliquity of these parts. Not unfrequently a distinct swelling may be observed in the iliac region or in the lower portion of the hypogastric. Defecation and micturition are attended with more or less difficulty, progression is painful, if not impossible, and the woman, as she lies in bed, usually retracts her limbs to relieve the abdomen of its tension. The attendant fever is variable. In general, it is well marked, with a distinct vesperal exacerbation; the pulse is hard, full, and frequent; the skin is hot and dry; the urine is scanty and high colored; the appetite is impaired; the thirst is considerable; and the sleep is disturbed.

Although such is the course of events generally in this disease, cases not unfrequently occur in which its approaches are extremely stealthy and insidious. Instead of pain, there is, perhaps, merely a sense of uneasiness and fullness in the pelvic region; the general health is disordered, but there is no decided febrile disturbance; and the discovery of the swelling in the side, the vagina, or the rectum, may be purely accidental. When the attack is consequent upon parturition, the characteristic symptoms may not make their appearance under several weeks, or until the patient is considered as perfectly convalescent.

The matter that forms during the progress of the disease generally escapes, unless evacuated artificially, through the rectum, the vagina, or the colon. Occasionally it passes off externally, through the walls of the abdomen, and cases have occurred in which it burst into the bladder, the peritoneal cavity, and even into the uterus, as in the remarkable instances related by Dance and Wainright.

The diagnosis is generally sufficiently easy. The most important circumstances are, the history of the case, the peculiar situation and character of the pain, and the presence of a tumor, generally readily detectable by the finger in the vagina and rectum, or by the eye and finger, as when the matter points in the iliac region. The affections with which it is most liable to be confounded are, peritonitis and inflammation of the ovary, or ovary and uterus. It may also be simulated by neuralgia of the pelvic viscera. In case of doubt the exploring needle is inserted. The formation of matter is sometimes indicated by rigors.

The prognosis is generally favorable, provided the case is properly managed. If

it be misunderstood, the matter may escape into the abdominal cavity, and speedily destroy life by the induction of peritonitis. When the abscess is allowed to open spontaneously, great, if not irreparable, mischief may be occasioned by the burrowing of the pus, and by the establishment of numerous sinuses, perforating, perhaps, the vagina, the rectum, or even the bladder.

The *treatment* is sufficiently obvious. The object, in the early stage of the disease, is to prevent the formation of matter, by antiphlogistic measures, especially rest in the recumbent posture, and the application of leeches to the perineum, vulva, and hypogastrium, along with medicated fomentations. If the patient is strong and plethoric, blood is freely taken from the arm, and the system rapidly brought under the full influence of antimonial and saline medicines. The lower bowel is emptied with enemata, but active purging must be avoided, as it would tend to irritate the affected parts. A laudanum injection generally affords great relief. As soon as the abscess points, a large incision is made into it, if possible, at its most dependent portion, to afford free vent to the pent-up fluid, which should on no account be permitted to burrow, otherwise troublesome, if not incurable, sinuses and fistules will be sure to follow. When the abscess opens spontaneously, the aperture should be enlarged with the probe-pointed bistoury, that the matter may escape as fast as it is formed. Cleanliness is promoted by the frequent use of the syringe charged with tepid water and chlorinated soda. The cure is often tedious. Change of air, tonics, and a full share of alcoholic stimulants will be required when there is much prostration.

SECT. XIII.—SEPARATION OF THE PELVIC SYMPHYSES.

Separation of the pelvic symphyses is liable to be produced by external injury, as when the body is jammed violently between two hard and resisting objects; but the affection which I am about to describe is not caused in this way, but by a process of inflammation and softening occasioned during pregnancy, apparently, as a consequence of the pressure of the child's head. The affection has not been noticed, so far as my information extends, by systematic writers on surgery; it is referred to by some of the older obstetricians, but it is only by Mr. John Burns, of Glasgow, that any detailed account of it has been given. The reasons of this silence are no doubt the great rarity of this occurrence, and its liability to be mistaken for rheumatism and other diseases.

The disjunction may be limited to one articulation, or it may attack all, either simultaneously or successively. The pubic symphysis, according to my observation, suffers more frequently than either of the sacro-iliac. The separation sometimes occurs during a first pregnancy, and I have noticed cases in which it showed itself in several consecutive terms. It seldom makes its appearance until the latter months of gestation. One attack does not necessarily predispose to another, unless the conceptions take place in rapid succession before the parts have recovered their natural tone.

The pathology of the disease is still undetermined. The probability is that the affection essentially consists in inflammatory softening, by which the cartilages are gradually disintegrated and broken down, so as to be incapable of holding the bones in their natural relations. The ligaments are, doubtless, also invaded, but to what extent is, of course, merely a matter of conjecture.

The symptoms are usually well characterized. The most prominent are, pains of a dull, aching nature in the region of the pelvis, increased by pressure, walking, and turning in bed, an unsteady, waddling gait, a sense of weakness in the lower extremities, great difficulty in progression, and inability to stand upon one leg. The slightest exertion causes fatigue and suffering; the feet are spread out in walking, and it is often impossible to maintain the erect posture without some support for the hands. A feeling of uneasiness and weight, as if a bar were stretched across the pelvis, is sometimes experienced. The articulations are tender on pressure, the back aches, and pains extend along the thighs, groins, perineum, and pelvis. The bladder is occasionally irritable, and now and then there is considerable leucorrhœa. The general health is often disordered, but there is seldom any fever. When the separation exists in a marked degree, the pelvic bones may be moved upon each other, and the patient is unable to walk or support herself in the upright posture. There is no discoloration or swelling of the skin, except when there is a tendency to suppuration. In some cases, the disjunction is so great that the point of the

finger may readily be pressed into the affected joints, especially the pubic. These symptoms generally come on during the latter months of pregnancy, but occasionally they are not noticed until several days after delivery.

The disease may be mistaken for rheumatism, scrofula of the sacro-iliac symphysis, sprains, and contusions. Errors will be best avoided by a thorough examination of the parts, and a careful consideration of the history of the case.

The prognosis is favorable. A long time may, however, elapse before a complete cure is effected. Abscess constitutes a serious complication; death has been known to occur from an extension of the disease to the peritoneum. Pelvic cellulitis sometimes arises during the progress of the case.

The most appropriate remedies are rest in the horizontal posture, the application of leeches to the affected joints, and an occasional laxative with a full dose of Dover's powder at bedtime. The local distress is generally promptly relieved by the use of a well padded belt, worn in such a manner as to afford firm support to the pelvic bones. With the aid of such a contrivance the patient is often able at once to sit up and walk about with little or no inconvenience. When the disease has reached the chronic stage, the cure will be accelerated by the employment of sorbefacient liniments, chalybeate tonics, the cold shower bath, and exercise in the open air. If matter forms, it must be speedily evacuated.

SECT. XIV.—IMPOTENCE AND STERILITY.

Impotence and sterility in the female are subjects of too much importance to be wholly overlooked in a treatise of this kind. When we consider how often the practitioner is consulted respecting them, and what amount of happiness or misery is involved in a correct answer, their gravity will be sufficiently apparent, both in a surgical and a medico-legal point of view.

The affections which give rise to impotence and sterility in the female are, like the analogous affections of the male, divisible into two classes, the curable and incurable. A woman who is incapable of copulating must necessarily be sterile; for, although her reproductive organs, properly so called, as the ovaries, Fallopian tubes, and uterus, may be perfect, yet, if the seminal fluid cannot reach its destination, conception cannot occur. On the other hand, she may be fully competent to perform the sexual act, and yet be incapable of offspring.

Most of the causes of impotence in woman are of a mechanical character, referable to certain conditions of the labia, the vagina, or the uterus. The labia may be firmly adherent to each other, in consequence of accident or disease; the vagina may be closed, extremely contracted, congenitally absent, or obliterated by inflammation; and the uterus may be procident, lying on the outside of the pelvis, between the thighs. Besides, there may be various morbid growths, both benign and malignant, occupying these organs, or obstructing the vulva, and thus interfering with penetration. Great deformity of the pelvis and of the thighs may render copulation impracticable, by preventing the approaches of the male. The existence of a hymen, however strong and resisting, would not be a complete barrier to the sexual congress. Vaginismus is frequently an effectual obstacle to copulation, the vagina being so exquisitely sensitive as not to tolerate the contact of the male organ. Enormous distention of the abdomen, such, for example, as occurs in some forms of ovarian dropsy, or ascites, may be a cause of impotence, and a similar impediment might be produced by an inordinate inguinal, labial, or femoral hernia. Some of these cases are curable, others are not. The necessary treatment will readily suggest itself from what has been said respecting it in different parts of the work.

A woman may be able to copulate, and yet not conceive. Various causes may conspire to produce such a result: as, 1st, absence, adhesions, stricture, or obliteration of the vagina, or a cul-de-sac of this canal above the neck of the womb, whereby the seminal fluid is prevented from reaching its destination; 2dly, an imperforate hymen; 3dly, absence, malposition, inversion, occlusion, or any serious disease whatever of the uterus; 4thly, congenital deficiency, obliteration, or morbid adhesions of the Fallopian tubes; 5thly, absence, disease, or degeneration of the ovaries; 6thly, imperfect menstruation and absence of sexual desire; 7thly, an acid condition of the mucus of the vagina and uterus, rapidly depriving the spermatozoa of their vitality; and, lastly, a want of fructifying property in the seminal fluid of the

woman. Ulceration of the neck of the uterus, profuse leucorrhœa, and excessive sexual indulgence may be included among the curable causes of sterility.

No conception can happen unless there is actual contact of the seminal liquors of the two sexes; hence, whatever prevents this occurrence is a cause of sterility. If this condition exists, it is not necessary that the female should experience any particular enjoyment; indeed, both sexual desire and gratification may be absent, and yet impregnation take place. The recent progress of uterine pathology, as developed by Bennet, Simpson, Tilt, Sims, and others, clearly shows that sterility, existing probably in one woman out of every ten, is due, in the great majority of cases, to some mechanical impediment to the passage of the semen, often perfectly remediable by surgical intervention. Among the more prominent and frequent of these causes are the various malpositions of the womb, as anteversion and retroversion, various curvatures, hypertrophy of the anterior and posterior lips, with abnormal narrowness of the canal of the neck of the organ, and occlusion of the mouth of the uterus, whether by tough, inspissated mucus, morbid adhesions, or polypoid growths. The proper mode of treating these affections has already been pointed out. The researches of Donne and others have shown that the spermatozoa lose their vitality very soon in acid mucus; and the seminal fluid furnished by the female, doubtless, generally shares a similar fate.

SECT. XV.—AFFECTIONS OF THE MAMMARY GLAND.

The mamma is liable to inflammation, abscess, hypertrophy, neuralgia, and various kinds of tumors, both innocent and malignant. The latter, in fact, appear to have a kind of preëmpion right to this organ.

MAMMITIS.

Inflammation of the breast, technically termed mammitis, or mastitis, is chiefly observed during lactation, in consequence of suppression of the cutaneous perspiration, or retention of the milk, causing overdistention of the lactiferous ducts. It may also arise from too free living, neglect of the bowels and secretions, and from the effects of external violence. It generally comes on within the first fortnight after parturition, beginning in the form of one or more ovoidal lobules, hard and tender to the touch, somewhat deep-seated, and not exceeding the volume of an almond. As the inflammation progresses, other lumps appear, and, gradually coalescing, at length involve the whole breast, glandular structure and connective tissue as well. The organ is now exceedingly large, hard, and heavy, exquisitely painful, and intolerant both of manipulation and pressure. The skin is hot, discolored, tense, and glossy, pitting, perhaps, here and there slightly under the finger. The secretion of milk is either arrested, or, at all events, much diminished, and great difficulty is experienced in emptying the organ, the choked-up ducts being seemingly indisposed to part with their contents. Well marked constitutional symptoms are always present at this stage of the disease. The patient is hot and feverish, or alternately hot and chilly, the tongue is dry and coated, the pulse is full and frequent, the bowels are constipated, and the urine is scanty, high-colored, and loaded with urates. If permitted to proceed, the inflammation soon passes into suppuration, the event being announced by the ordinary local and constitutional phenomena, especially throbbing, an erysipelatous blush of the skin, and rigors alternating with flushes of heat.

The treatment of acute mammitis is strictly antiphlogistic, early and vigorously enforced. If the patient is very plethoric, blood is taken from the arm, or by leeches from the seat of the disease, the bowels are moved by active purgatives, vascular action is controlled by tartar emetic and sulphate of magnesia in combination with aconite, and the lightest possible diet is enjoined, with an avoidance of fluids of every description, thirst being allayed by the use of ice. The breast is supported with an appropriate bandage, and the surface is kept constantly wet with warm water-dressing, medicated with acetate of lead and laudanum. If suppuration be threatened, an emollient poultice, if not too heavy, will generally be found to be very grateful. Pain is allayed by anodynes, conjoined with diaphoretics, especially if there be dryness of the skin. The breast should be relieved at least twice a day

of milk, either by suction with the mouth or by a suitable pump, the child receiving its nourishment from the sound organ.

A speedy check may often be put to an incipient mammitis by rubbing the affected organ thoroughly several times a day with warm oil and laudanum, or mild ammoniated liniment, the friction being made in the direction of the lactiferous ducts, that is, from above downwards towards the nipple, by the nurse, as she stands behind the patient, and supports the posterior surface of the breast with one of her hands. This mode of treatment, which is particularly insisted upon by Dr. S. C. Foster, of New York, generally exerts a powerful effect upon the indurated gland, softening it in a short time, reducing the swelling and promoting the flow of milk by relieving the lacteal ducts of congestion.

When the disease has lost its acute character, sorbefacient liniments and unguents may advantageously be employed; or, what is often much better, strapping of the breast with adhesive plaster, on the same principle as in chronic inflammation of the testicle. Each strip should be three-fourths of an inch in width, and long enough to extend once and about a third around the organ, the application being commenced at the base, and continued by circular and vertical turns, until the whole is completely enveloped, a suitable opening being, of course, left for the nipple. The dressing will require renewal about every forty-eight hours. The local treatment in these chronic cases is generally greatly promoted by a properly regulated diet, and by an occasional cathartic of black draught, or blue mass and colocynth.

ABSCESS.

When mammitis passes into suppuration, the matter always collects in the form of an abscess, which may be situated either in the interlobular substance of the gland, in the cellulo-adipose tissue beneath the skin, or in the connective substance behind the organ, the frequency of the occurrence being in the order here stated. The symptoms denotive of the event are, an increase of pain, which is throbbing, deep-seated, and continued, a dusky or purplish appearance of the skin, a sense of fluctuation, especially if the matter has already accumulated in considerable quantity, and rigors or chilly feelings, alternating with flushes of heat, and followed by copious sweats. When the pus is situated at an unusual depth, its presence is often indicated by an œdematous state of the subcutaneous cellular tissue.

The matter which is formed in this disease is generally of a thick, cream-like consistence, and of a whitish or pale yellowish color. When the inflammation has been very high, it is apt to contain flakes of lymph and pure blood, the latter being usually in a state of coagulation. Milk is almost always a prominent ingredient. Even when it exists in so small a quantity as to be undiscoverable by the naked eye, its presence may, generally, be readily detected by the aid of the microscope. The quantity of pus varies from a few ounces to upwards of a quart, the average being from four to eight ounces. From a week to a fortnight is the time required by the abscess to work its way to the surface.

The treatment of mammary abscess consists in an early and free incision, for the twofold purpose of relieving pain and saving structure. The edges of the wound are prevented from closing by the use of the tent. The most suitable application for the first few days is an emollient poultice, or the warm water-dressing. All rude squeezing, with a view of promoting the evacuation of the pus, must be avoided, as it is calculated not only to produce pain, but to aggravate inflammation.

When the treatment of mammary abscess has been neglected or mismanaged, the matter is extremely apt to burrow, dissecting the lobules of the glands from each other, and also, in many cases, from the surrounding parts, thus causing extensive havoc, and the formation of numerous sinuses; sometimes as many, perhaps, as half a dozen. Such cases are always attended with great suffering, both local and constitutional. Until lately, the treatment used to be as cruel as it was generally tedious and unsatisfactory, the object being to trace out the passages with the director and knife, with a view, as was alleged, of healing them from the bottom, a tent being maintained in them for the purpose. Within the last few years, a more scientific mode of management has been extensively pursued in this country, in consequence of the recommendation of Dr. Foster. It consists simply in the application of compressed sponge, confined by means of an appropriate bandage, aided by a suitable diet, and attention to the bowels. The sponge, freed of dirt, perfectly

soft, elastic, and large enough to cover the entire breast, is thoroughly dried, and then effectually compressed by keeping it for twenty-four hours under a heavy weight, as, for example, a common letter copying-press. Thus prepared, it is bound upon the affected organ over a piece of patent lint, to prevent irritation of the skin, by means of a roller passed several times around the chest, above and below the sound breast. It is then saturated with tepid water, which has the effect of expanding it towards the diseased structures, pressing the walls of the sinuses together, and at the same time forcing out their contents and absorbing them. The sponge is changed once in the twenty-four hours. A little pain generally attends the first application, but this usually disappears in fifteen or twenty minutes, and does not recur afterwards. The improvement under this treatment is most rapid, the worst cases generally recovering in a few weeks. If the general health is much impaired, it should be conjoined with the use of tonics, a nourishing diet, and exercise in the open air. In addition to these measures, the cure will be expedited if the child be weaned, as suckling of the sound breast keeps up vascular excitement in the one that is inflamed.

In my own practice, I have usually succeeded, without difficulty, in relieving such cases by systematic compression with adhesive strips, or, what is better, with strips of ammoniac and mercurial plaster, applied quite firmly, and in such a manner as not to interfere with the discharges. Indeed, I have often effected excellent cures simply by wrapping up the breast in the plaster, without cutting it into strips.

The *chronic abscess* of the breast is often a very troublesome and annoying affection, the more so because of the difficulty occasionally experienced in the diagnosis. I have repeatedly had patients sent to me from a great distance under the supposition that they were laboring under malignant disease of the mamma, when their only ailment was a chronic abscess. What is still worse is that the organ has occasionally been extirpated in such cases, as I have myself known it to be in two instances. Such a proceeding cannot be too severely reprehended, especially as there is not the slightest excuse for it, the use of the exploring needle always promptly revealing the true nature of the disease.

There is no doubt that the chronic mammary abscess is occasionally of a strumous nature, especially when it attacks, as I have known it to do in a number of instances, young, unmarried females; but, in general, it will be found to be the result of ordinary inflammation, occurring during suckling, and proceeding in a very slow and stealthy manner, in consequence of some defect in the constitution, or of some obstruction in the lactiferous ducts. In most cases the disease takes place in the breast which the child has been unable to use on account of an inflamed, chapped, or retracted nipple. Sometimes the exciting cause is a blow or contusion, perhaps so trivial as at the moment not to attract any attention.

The disease usually begins in the form of several hard lumps, which, gradually coalescing, at length unite into one solid mass, of irregular shape, and of firm consistence; sometimes involving only a portion of the breast, and at other times the entire organ. Occasionally the glandular structure escapes completely, the morbid action being confined exclusively to the cellular tissue around, behind, or in front of the breast. By and by, a process of softening begins, and, steadily progressing, a large accumulation of pus occurs, pressing upon the parts in every direction, and fluctuating distinctly under the finger. Marked enlargement of the subcutaneous veins usually attends, especially when the disease is of long standing, but there is no discoloration of the skin, and seldom any severe pain; merely, perhaps, a sense of weight and of uneasiness. The general health is not materially affected, and there is no involvement of the surrounding lymphatic glands. The disease may last for months.

The treatment of chronic mammary abscess is by evacuation, and support of the breast by the ammoniac and mercurial plaster, aided by compress and bandage. Unless this precaution be used, there will be danger of hemorrhage from the rupture of the weakened vessels of the walls of the abscess. In a case communicated to me by Dr. Walter, of Nazareth, bleeding came on a week after opening a large swelling of this kind, and was so copious as almost to exhaust the patient. It was at length checked by the pressure of a common spring truss. When the matter has been evacuated, recovery will be promoted by attention to the diet and bowels, by exercise in the open air, and by the use of tonics and alterants. The cure is generally perfect.

GANGRENE.

The mammary gland is singularly exempt from gangrene. Such an occurrence, indeed, is possible only in very unhealthy females, or in women who, in addition to scrofulous or syphilitic disease, are suffering, at the time of the inflammatory seizure, under an impoverished state of the blood. A few cases are upon record in which gangrene of this gland was occasioned, in middle-aged females, by the protracted use of ergot. In erysipelas and carbuncle the cellular tissue around the gland sometimes mortifies, the mamma itself generally escaping. The treatment of this affection, however induced, is to be conducted in the same manner as in gangrene in other parts of the body.

LACTEAL ENGORGEMENT.

Lacteal engorgement of the mamma must not be confounded with abscess or the lacteal tumor, properly so called. It is simply, as the name signifies, an accumulation of milk in the lacteal ducts, and is usually caused by an imperfect evacuation of their contents. The breast, thus affected, may exceed many times its natural bulk, and contain an enormous quantity of fluid. In a case observed by Dr. Charles R. Cleveland, in a woman, twenty-two years of age, the right gland, three days after delivery, measured forty-two inches in circumference by twelve inches and a half in length, and the left thirty-six by ten. Both organs were of a firm, dense consistence, free from pain, tenderness, or fluctuation, and traversed by numerous large veins. The integument was stretched to its utmost, the arms felt benumbed from the pressure of the tumors upon the axillary nerves, and the pulse could hardly be perceived at the wrist. A gallon of milk was removed with the aid of a pump within ten hours. The breast had been unusually large and flabby from early girlhood.

The treatment is by suction with the breast pump, cicuta plasters, purgatives, a dry diet, and the exhibition of sorbefacient medicines, as cicuta, belladonna, and iodide of potassium.

SYPHILITIC AFFECTIONS.

The fact that the breast is liable to syphilis in its tertiary form is a discovery of modern times, due to the researches of the French and Italian surgeons, especially Maisonneuve, Verneuil, and Ambrosoli, the two latter of whom have met with it in both sexes. The affection, constituting what is known as syphilitic mastitis, occurs in two distinct forms, the circumscribed and the diffuse, the former presenting itself, as the name implies, in small, hard, more or less numerous nodules, and the latter as a general induration of the gland. The tubercles are of a gummy character, similar to those that are met with in the cellular tissue, the testicle, and the different internal organs. The malady seldom makes its appearance before the second or third year after the primary affection, and generally attacks both breasts at the same time, or in more or less rapid succession.

The diseases with which syphilis of the breast might be confounded are carcinoma and adenoma, from both of which, however, it may generally be readily distinguished by the history of the case, as the existence of syphilis in other parts of the body, the absence of pain and axillary involvement, and the symmetrical character of the affection, both glands, as was originally remarked by Sauvages, usually suffering simultaneously. The ulcer, consequent upon the softening of the gummy tubercle of the breast, has hard, undefined edges, with a tendency to the formation of deep sinuses, and the discharge is of an unhealthy, whitish, mucus-like appearance and consistence, entirely different from that of a carcinomatous ulcer. An adenoma of the breast is generally of uniform hardness, of slow development, and without any disposition to softening, so common in syphilis. The effects of treatment will often do more to clear up the diagnosis than anything else.

The treatment of syphilitic mastitis is conducted upon the same principles as in specific orchitis, the iodides and bichloride of mercury being the principal internal remedies, and iodine, leeches, acetate of lead, and cataplasms the most important local ones. Any matter that may form must be early evacuated. Strapping the breast with ammoniacal and mercurial plaster is often serviceable.

NEURALGIA.

Neuralgia of the breast may occur at any period after puberty, but is most common in young females from the age of fifteen to thirty. It is characterized by exquisite pain, darting through the part like electricity, and extending generally to the corresponding shoulder and axilla, and sometimes down the elbow to the fingers. The suffering, which resembles that of *tic douloureux*, and which often observes a regular periodicity, is very much increased prior to menstruation, and is sometimes so severe that the patient is unable to lie upon the affected side, or bear the weight of the bedclothes. The disease, which may last for years, is met with mostly in persons of a nervous, irritable temperament, with deficient menstrual secretion.

The morbid action is commonly confined to several of the mammary lobules, which either retain their natural bulk and appearance, or, what is more common, they are converted into small, solid tumors, distinctly circumscribed, movable, and highly sensitive to the touch. Occasionally these swellings seem to be seated in the connecting cellular tissue rather than in the glandular structure; they seldom exceed the size of a marble, an almond, or a walnut; they never suppurate, and they sometimes disappear spontaneously.

More or less disorder of the general health usually attends; the patient looks pale and thin, is remarkably susceptible to atmospheric impressions, and nearly always suffers under marked derangement of the menstrual function, the discharge being unusually scanty, and accompanied with a great deal of pain. In most of the cases that have fallen under my observation, the disease was associated with neuralgia in other parts of the body.

The treatment is to be conducted upon ordinary antineuralgic principles. The general health having been amended by a proper regulation of the diet and the use of purgatives, the patient is placed under the influence of quinine, or, if there is evidence of anemia, quinine and iron, in union with arsenic, strychnia, and aconite, cannabis Indica, or stramonium, steadily and persistently continued, with an occasional intermission, until a decided impression has been made upon the complaint. Sometimes the exhibition of colchicum and morphia proves highly beneficial; and I have seen cases in which nothing appeared to answer so well as antimonial and saline preparations, with aconite. The most suitable local remedies are anodyne liniments and plasters, preceded, if there is considerable tenderness and swelling, by leeching. The breast must be well supported and protected from pressure. The menstrual function must receive due attention.

HYPERTROPHY.

General hypertrophy of the mamma, fig. 701, is not common, nor is it, as might be supposed, confined entirely to the female sex. I have repeatedly seen both breasts of the male enlarged many times beyond their normal bulk, and not a few cases are recorded where they freely, and for a long time, secrete milk. The affection, which is entirely distinct from the swelling that is so commonly associated with amenorrhœa, sometimes occurs during pregnancy, and disappears soon after delivery, but it generally begins at an early period of life, and goes on progressively increasing until the breast acquires an enormous bulk. Of this, an interesting case came under my observation in 1857, in a colored girl, nearly seventeen years of age, a patient of Dr. Hanly, of this city. The hypertrophy involved both organs, but not in an equal degree, the right being more than twice the volume of the left, and weighing, by estimate, upwards of fifteen pounds, its length exceeding fifteen inches. They were of a very firm consistence, considerably nodulated, and very tender on manipulation. The

Fig. 701.



General Hypertrophy of the Mammary Gland.

subcutaneous veins were enormously enlarged. The without any assignable cause, when the girl was twelve saw her, she had been confined a fortnight, and I was much increased in size both during and since her pregnancy had become much impaired, and she was excessively case of this kind, in which the left breast weighed six pounds. I successfully extirpated both glands, the patient losing the weight of her entire body.

The true nature of this disease is not accurately determined. In one class of cases, the organ retains its normal structure, which is mostly ex another class of cases, it is of the character of true acromegaly, or hyperplasia of the glandular elements, or great development of a corresponding increase in the quantity of the interlobular tissues. In a third class of cases, again, the hypertrophy consists in the development of the adipose tissue. Under such circumstances, the masses, upon its anterior and lateral aspects, very literally lying behind the breast, between it and the pectoral muscles, are most common after the decline of the menses, in women whose powers have naturally been rather weak. The growth is characterized by a soft, doughy consistence, by a sensible enlargement of the subcutaneous veins, and by an unimpaired general health. In a case related by Dr. John C. Warren, which is unequivocal, the weight of the breast, after extirpation, was found to be chiefly due to an increased development of the interlobular tissue.

The treatment of mammary hypertrophy is general, and rests upon the same principles. The use of sorbefacients would necessarily succeed, but it does not appear that it has hitherto been of any great service. A suitable article would be iodine, administered internally, or in the form of tincture or of ointment. It might be serviceable. Occasionally benefit has accrued from the use of hydrochlorate of ammonia, in doses of five grains thrice a day. Whatever remedies be employed, special attention should be given to the improvement of the general health, which is often the most important consideration, to take off weight and tension by means of ammonia and mercurial plaster would probably be of more beneficial influence than any other local means, although it has never been fairly tested. Extirpation should be resorted to only when the tumor, if it yields to treatment, is so large as to cause severe distress, or gradually, but effectually, undermining the general health.

ATROPHY.

Atrophy of the mamma is a natural effect of old age, when lactation ceases, the gland begins to diminish in volume, and at length, the whole organ is reduced to a grayish tint, in which it is often difficult to detect any change, except the lactiferous ducts, which are seldom completely obliterated. The gland shrinks early in life, particularly in married females who have no offspring. Atrophy of this viscous occasionally results from the use of certain medicines, as iodine and hemlock.

The lesion presents little of surgical interest. When it is the consequence of the use of certain medicinal agents, sure, immediate measures should be adopted for its arrest, lest it be irretrievably lost.

FISTULE.

During lactation, a milk duct is sometimes included in the areola, and, unless the edges are very closely approximated, the same consequences may be produced by a rupture of the duct, and a purulent accumulation of milk. A more common occurrence is the formation of a fistula, which is usually attended with considerable pain, and is often the result of a rupture of the duct, or of a rupture of the areola.

accidental outlets, from the irritation of multilocular abscesses. These passages are often of considerable depth, tortuous, numerous, lined by an adventitious membrane, and attended with a great deal of induration of the surrounding parts. The nature of the affection is generally easily determined by the character of the discharge and a careful examination with the probe.

The disease will usually disappear of its own accord, as soon as lactation is over, and frequently even long before that event. If the case is troublesome, a cure should be attempted by the application of compressed sponge, conjoined, if necessary, with stimulating injections.

CALCAREOUS CONCRETIONS.

Calcareous concretions are met with in the breast, either in its substance or in the lactiferous ducts; they are commonly small, not exceeding an ordinary pea, and are observed chiefly in connection with fibrous and other tumors. I have seen these bodies only in two instances, in females far advanced in life. They were of a whitish color, irregularly spherical in shape, and of a hard, solid consistence, like dry mortar. A case has been described by Bérard, in which the walls of a cyst of the mamma were converted into a complete osseous shell.

Unless these concretions prove a source of inconvenience or annoyance, they should be let alone, especially if the patient has not passed the child-bearing period, as an operation might be attended with serious injury to the lactiferous tubes.

APOPLEXY.

The breast is liable to apoplexy, consisting in an effusion of blood into the connecting cellular tissue, resembling an ecchymosis produced by a blow or leech-bite. Generally there is only one such spot, but there may be several, coming on a few days before the menstrual period, and disappearing within the first week or two after; although sometimes they continue for more than a month. The disease seems to depend upon some sympathetic action between the uterus and the breast, causing a great determination of blood to the latter, eventuating in the rupture of some of its smaller vessels. It is most common in girls suffering from amenorrhœa and dysmenorrhœa, and is, apparently, now and then vicarious of the menstrual function. The affected parts are always of a dark, livid hue, and are exquisitely tender on pressure, the pain sometimes shooting down to the ends of the fingers.

The *treatment* consists in sorbefacient applications, especially if some time has elapsed since the occurrence of the disease. When the effusion is recent, it will generally promptly disappear under cold saturnine and opiate lotions.

BENIGN TUMORS.

Under this head may be included various kinds of growths of a benign or non-malignant character, as the cystic, fibrous, adenoid, fatty, and cartilaginous.

1. CYSTIC TUMORS.

Cystic tumors of the breast may be classified, in accordance with the mode of their development, as retention, or duct cysts, and cysts of new formation; or they may more appropriately be described, according to the nature of their contents, as lacteal, oily, serous, and hydatid cysts.

a. *Lacteal Cysts.*—The breast, in consequence of the occlusion and distention of some of its lactiferous ducts or sinuses, is liable to an inordinate accumulation of milk, forming a distinct swelling, commonly known as the milk tumor. It is generally of a globular or ovoidal shape, and is capable of acquiring a large bulk, as is evident from some of the reported cases. Thus, in one related by Dr. Willard Parker, in a woman thirty-five years of age, three quarts of fluid were evacuated at the first operation, and half that quantity in a week afterwards. In an instance recorded by Scarpa, the breast measured thirty-four inches in circumference, and gave vent, on being punctured, to upwards of a gallon of pure milk. In these cases

of enormous volume, the milk, instead of being retained in a dilated duct or sinus, is poured out into the connective tissue of the gland, which is thus gradually condensed into a kind of cyst. The swelling usually begins within the first month after delivery, and often attains a large bulk in a few weeks. It is attended with a peculiar sense of distention, without any decided pain, distinctly fluctuates under the finger and enlarges during sucking. On cutting into it, the contents are found to be of a whitish color, and of the consistence of milk, cream, or whey. The general health is unimpaired. When the tumor is unusually voluminous, there is always marked enlargement of the subcutaneous veins.

A case has been recorded by Wormald, in which a small cystic tumor of the mamma was filled with what appeared to be pure oil, that coagulated into a substance resembling lard, intermixed with crystals of margarine. I have myself met with an example of mammary cyst partially filled with oil and a substance like curds, the result evidently of degenerated milk.

There is a form of milk tumor of the breast, in which the contents are of a solid character, bearing a close resemblance to butter, and hence called the *butyroid* tumor. It consists of a cyst, inclosing a yellowish, concrete substance, of the appearance of butter, cheese, or casein, and due to altered milk, the more fluid portions of which are absorbed, while the solid are retained, and thus gradually assume the properties here assigned to them. The disease is very uncommon, and the diagnosis must necessarily be obscure.

The *treatment* of the milk tumor should be conducted upon the same principle as that of any other cystic formation; that is, either by the injection of some stimulating fluid, as the dilute tincture of iodine, by the seton, or by the tent, care being taken that the resulting inflammation does not run too high. When the tumor is solid, the proper operation, of course, is excision.

3. *Serous Cysts*.—Sero-cystic tumors of the breast are sometimes met with; chiefly in married females between the twentieth and fortieth years. The affection is strictly of a benign character, and never recurs after thorough removal. Its progress, always very tardy, is seldom attended with any decided disorder of the general health, the chief inconvenience caused by the morbid growth arising from its weight and bulk, which are sometimes enormous.

The disease is due either to obstruction with retention of the contents of a single duct, or to interstitial new formations whereby a portion of numerous tubules is compressed and obliterated, and the remainder dilated by its accumulated secretion and converted into more or less globular sacs. In the former event the cyst is single and isolated; in the latter multiple, the gland being often literally stuffed with them.

Two distinct forms of cystic disease of the breast are met with, the unilocular and the multilocular. In the former, the cyst, as the name implies, is single, and composed of a membrane which bears a very close resemblance to the peritoneum, its inner surface being perfectly smooth and glossy, and lined with squamous epithelium, while the outer is intimately connected to the surrounding parts. Occasionally the cyst is intersected by membranous bands, separating it into a number of distinct compartments, of varying size and shape. When this is the case, the cyst is said to be *multilocular*. Various fluids are found in these sacs. Generally they are of a serous nature, more or less viscid, coagulable, of a saline taste, and of a limpid, or pale yellowish appearance; but cases occur in which, from the admixture of hematin, they are of a reddish, olive, brownish, claret, or blackish hue. Not long ago, I saw an instance in which the fluid was of the color of the tincture of iodine. Sometimes, again, the fluid is of a lactescent nature, whey-like, or mucoid. Finally, there are cases in which it contains cholesterine, flakes of lymph, and other substances. Cysts of the character now described often attain a large bulk, and are capable of holding from twenty to sixty ounces of fluid.

Very frequently, again, the cysts are *multiple*, their number, perhaps, ranging from a few dozens to many hundred. When this is the case, they are generally very small, their volume varying from that of a hemp-seed to that of a pigeon's egg. Their shape is usually spherical, ovoidal, or conical. When young, they are smooth, transparent, elastic, vascular, closely adherent, and filled with a clear, watery fluid, slightly saline in its taste, and scarcely coagulable by heat, alcohol, or acid. Their parietes, however, are liable to become opaque and thickened, when the contained fluid

may be lactescent, bloody, oleaginous, glairy, or gelatinous. Different cells of the same tumor often have dissimilar contents. The morbid mass is sometimes entirely composed of cysts; at other times a considerable proportion of solid matter is interposed between them, commonly of a tough, fibrous nature. The characters of the multiple form of this disease are well seen in fig. 702, from a preparation in my cabinet.

Single or multiple cysts, uncombined with a contracted state of the connective tissue, are most common in young adults during the period of activity or evolution of the mammary gland, whence they are sometimes termed evolution cysts. The cystic tumor is not unfrequently blended with condensed and thickened interstitial tissue, the two elements being more or less intimately intermixed with each other. This is especially true of the multiple or polycystic variety, of long standing, in females after the decline of the menses. The cysts, under such circumstances known as involution cysts, are very thick, dense, opaque, and occupied either by solid or semisolid formations. Such tumors, not inaptly termed *fibro-cystic*, often grow quite rapidly, and are capable of acquiring a very large bulk.

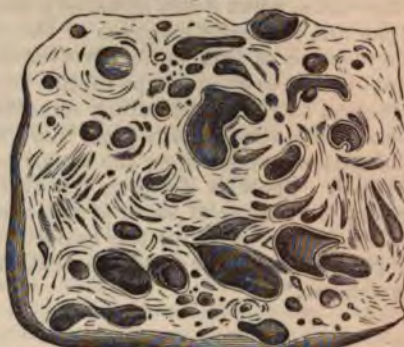
The *diagnosis* of cystic disease of the mammary gland is often obscure, especially in its earlier stages. The chief signs of distinction are, the gradual and steady growth of the tumor, the absence of pain and of lymphatic involvement, a sense of fluctuation, more distinct at some points than at others, the natural appearance of the integument, and the integrity of the general health. In some cases a serous or bloody fluid constantly flows from the nipple, or may be made to escape by gentle pressure, an occurrence which must be regarded as of great value in a diagnostic point of view. Any doubt that may exist may usually be promptly dispelled by a resort to the exploring needle. When the mass is of a fibro-cystic character, one part will be hard and inelastic, the other soft and fluctuating. When the tumor is large and old, it sometimes manifests a disposition to ulcerate, but, in general, as it goes on increasing, the skin gradually accommodates itself to its size.

The *treatment* varies. The unilocular form of the disease sometimes disappears under the steady use of discutient remedies, as a strong solution of hydrochlorate of ammonia, or a mixture of equal parts of alcohol and spirit of camphor, with a small quantity of Goulard's extract. Sometimes, again, a cure may be effected with the seton, the injection of iodine, or the insertion of a tent. When the cyst is old, unusually large, or partially filled with solid matter, nothing short of excision will answer, and there is the more reason for its performance when there is a probability that the tumor has completely annihilated the glandular structure of the organ. The only remedy, when the growth is multiple or multilocular, is thorough ablation.

γ. *Hydatid Cysts*.—Hydatids seldom infest this gland, at least in the females of this country. In the examination of a great number of breasts, I have not met with more than two cases. They always belong to the class of echinococci, and are most common between the ages of twenty-five and fifty. Varying in volume between a currant and an orange, they may occur in any portion of the organ, the proper substance of which they generally completely destroy. They are of a globular figure, and present themselves either in clusters, or as bodies perfectly distinct from each other. When of considerable size, it is not uncommon to find within the old hydatids young ones, hanging by narrow footstalks, and having precisely a similar configuration and structure. The contained fluid is generally thin and limpid, but it may be thick and glairy, like the white of an egg. In the older hydatids, especially such as are partially dead, there is sometimes an admixture of blood, pus, albumen, or curdy matter. These bodies may exist either alone, or in connection with other morbid products; and, when bulky and numerous, are productive of extraordinary enlargement of the breast, cases now and then occurring where the organ weighs from eight to ten pounds.

As in the ordinary cystic tumor, so in this, the diagnosis is often very difficult, if not

Fig. 702.



Cystic Disease of the Breast.

impossible. In its earlier stages, the disease is liable to be confounded with scirrhus; afterwards, when it has attained a large bulk, with encephaloid. The most important signs are, the tardy progress of the case, the unimpaired state of the general health, the absence of lymphatic involvement, the natural appearance of the skin, and the globular or ovoidal shape of the tumor, together with its large size and want of adhesion to the surrounding structures. The pain is usually much greater than in mere cystic disease, although there is sometimes none at all, and there is but little fluctuation, except when the tumor has acquired a large bulk, when it is always well marked. There is nothing, however, of a truly diagnostic character in any case, except the escape of some of the contents of the tumor.

The only remedy for the hydatid tumor is thorough excision, performed as soon as possible after the establishment of the diagnosis. The operation is not followed by relapse.

2. FIBROID AND ADENOID TUMORS.

The mammary gland is a frequent seat of fibrous growths, either in the form of diffuse fibrous transformation or as circumscribed, partial neoplasms. In the first variety the interstitial connective tissue is condensed into a firm, contractile, fibrous substance, imparting to the touch the sensation of atrophic scirrhus, which it sometimes closely resembles in its coarser features. In its earlier stages the acini and tubules are little, if at all, changed, but, as the disease progresses, they wither and finally disappear. In some cases, and particularly in elderly females, there is a secondary development of cysts, thus giving rise to the fibro-cystic tumor, or, as it may be more properly termed, the cystic fibroma, to which allusion has already been made under the head of cystic tumors. In another class of cases the connective tissue shrinks, the glandular elements disappear, the nipple retracts, and the breast is converted into a small, indurated mass.

In the second variety of fibrous tumor the changes in the glandular connective tissue are limited to circumscribed portions of the mamma, particularly at its circumference, where one or more small, firm, dense, lobulated nodules are developed, which are usually termed adenomas or adenoid tumors, as they contain gland structures, the proportion of which varies in different specimens. These mammary glandular tumors, as they are sometimes termed, are not, however, in the strict sense of the term, adenomas. A pure adenoma, which is one of the rarest of all neoplasms of the breast, is characterized by the formation of new glandular elements, the epithelium of which, along with the interacinous connective tissue, does not differ, or only very slightly, from the usual physiological type. Hence, an adenoma is to be viewed only as a partial hyperplasia of the glandular substance, its point of origin being the epithelium of the lobules. Usually developed in young females soon after marriage, and during the first pregnancy, it forms a firm, elastic, circumscribed, lobulated tumor, which rarely exceeds the volume of an almond. Its growth is very slow; it is occasionally painful; is often surrounded by a complete capsule, and is generally imbedded in the substance of the gland, with which it is intimately connected through the tubules which pass from it to join the larger ducts. Of many specimens of so-called adenoma which I have had subjected to microscopical examination, in none was there any epithelial hyperplasia. In all the point of departure of the neoplasm was the connective tissue, and in nearly all acini and ducts were present in a very abundant fibrous or young spindle-celled tissue, which was evidently obliterating, by its pressure, the lumen of the tubes. In a few instances the glandular elements had entirely disappeared, the mass being composed either of succulent, spindle-celled, or rapidly growing connective tissue, or a dense, firm, compact, fibrous substance, creaking under the knife, and occasionally containing calcareous deposits. If, when glandular elements are present, it be deemed desirable to recognize their existence, such tumors may be termed adeno-sarcomas or adeno-fibromas, but as these elements are merely included normal, and not new developments, to avoid confusion, it is best to speak simply of a fibroma, or a sarcoma, as the case may be, reserving the term adenoma, or adenoid tumor, for those rare growths in which there is a new formation of genuine, regularly constituted acini and ducts.

The fibrous tumor of the mamma, whether single or multiple, is firm, elastic, lobulated, and movable, notwithstanding that it is more or less adherent to the portion of the gland from which it immediately arises. It is commonly situated beneath

the surface, at the upper and inner part of the breast, and, when small, does not differ in its general features from the adenoid formation, although, unlike the latter, it often acquires considerable bulk, producing perhaps, ultimately, great inconvenience by its weight. The subcutaneous veins become gradually enlarged, but there is hardly any pain, and no involvement of the neighboring lymphatic glands. The disease usually arises without any assignable cause. The prognosis is favorable, but it must be guarded when the mass is composed of succulent embryonic or rapidly growing connective tissue.

There is a variety of fibrous tumor of the breast in which the structure is more complicated, rapidly proliferating connective tissue projecting into and filling the distended ducts, in the form of vascular, papillary, fimbriated, dendritic, or cauliflower-like vegetations, or of polypoid, lobed, spheroidal, rounded, or flattened masses, thereby giving rise to *proliferous fibroma*, or, as it is termed by Virchow, papillary intracanalicular fibroma. The section displays a smooth, dense, glistening, fibrous tissue traversed by variously shaped fissures, tortuous spaces, or clefts representing the altered ducts, upon separating the walls of which the vegetations are disclosed. In a specimen in my cabinet, the appearances of which are rudely represented in fig. 703, removed from a married, but sterile, female, thirty-three years of age, each breast was filled with small, tough masses of proliferating connective tissue, of a rounded form, from the size of a filbert to that of a common hickory nut, hard, and almost inelastic. The disease had been in progress for upwards of three years, and was attended with considerable enlargement of each gland, but there was an entire freedom from pain, lymphatic involvement, and disorder of the general health. The organs were perfectly movable, and numerous nodules could be felt in their substance in every direction. The nipples were badly developed, but not more retracted than they often are in women who have never borne children.

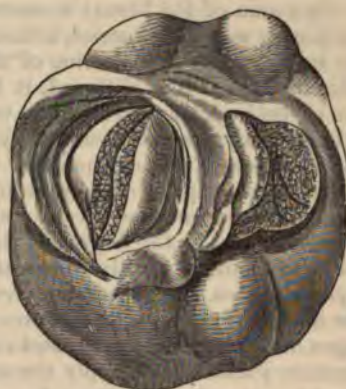
Upon making a careful examination of the nodules above described, I found that they all consisted of a kind of cyst, inclosing a mass bearing a striking resemblance to a cauliflower, being composed of fibrous membrane, of a white, glistening appearance, thin, and semitransparent, folded like the ruffle of a shirt, and studded with an immense number of small, delicate excrescences, looking very much like the warts which are so often met with upon the penis. They all adhered by a broad base or stem, and were made up each of a number of minute granules, resembling the eggs of certain insects. Under the microscope, Dr. DaCosta and myself found the stems to consist of fibrous tissue in various stages of development, continuous with that of the gland itself, while the granules were made up, for the most part, of rounded bodies, presenting a delicate, fibrillated stroma, inclosing small, ovoidal, and spindle-shaped cells in varying proportions. The hard part of the mamma, that in which the nodules were developed, was composed of bundles of very dense fibrous tissue, wavy, and extremely distinct. Fat cells were here and there discernible in its meshes.

The only reliable remedy in the treatment of adenoma and fibroma is excision, but such a measure will only be required in the event of the morbid growth being very large, painful, or inconvenient by its weight. Sorbefacient applications, and the exhibition of iodine, are usually of no benefit. Compression might be tried in the earlier stages of the disease.

3. LIPOMATOUS AND CARTILAGINOUS TUMORS.

The *fatty tumor* of the breast is uncommon. I do not recollect ever to have seen an instance of it. The growth is generally situated behind the gland, between it and the pectoral muscle, but cases occur in which it lies in front, and now and then the organ is completely imprisoned in it, the morbid mass being intimately connected with its interlobular cellular substance. The tumor is sometimes of enormous bulk.

Fig. 703.



Proliferous Fibroma of the Mamma, exhibiting its Lobulated Arrangement and two Dilated Ducts, containing the New Growths, laid open.

Thus, in a case observed by Sir Astley Cooper, it was thirty-one inches in circumference by ten and a half in length, and weighed upwards of fourteen pounds after removal.

The difficulty of distinguishing such a tumor is strikingly exemplified in a case related by Brodie. A lady, he remarks, had a growth in her breast, concerning which she obtained the opinions of some of the leading surgeons of that day. "One thought that it was fungus hematodes, another believed that it was something else, and another could not say what it was. At last it was decided to cut down on the tumor, and then it was found to be a great mass of fat." It was situated behind the breast, which it had pushed out in such a manner as to give it an unnaturally prominent appearance. Mr. Birkett, of London, in 1868, showed me a fatty tumor in the museum of Guy's Hospital, which had grown in front of the breast for fifty-two years, and which, by its pressure, had nearly destroyed the glandular tissues.

The only remedy is extirpation, and, in performing the operation, care must be taken not to inflict any serious injury upon the breast, although it will be very difficult, if not impossible, to preserve it when the tumor is very large.

The *cartilaginous* tumor is exceedingly rare. Small nodules of pure cartilage tissue are now and then met with as an interstitial new formation, but it is usually combined with carcinoma and sarcoma. In the case of a woman, thirty-two years of age, recorded by Sir Astley Cooper, a tumor of the mamma of fourteen years' duration was partly cartilaginous and partly ossified. The diagnosis is based upon the tardy development and dense consistence of the new growth.

MALIGNANT TUMORS.

The most common malignant diseases of the mamma are sarcoma, scirrhus, and encephaloid. Melanosis, epithelioma, and colloid are extremely infrequent.

I. SARCOMA.

Sarcoma of the breast is essentially an affection of early life, being most common in young married females, although it is now and then observed in impubic girls and in women after the decline of the menses. Occurring in two varieties of form, the circumscribed and diffused, it is usually made up of small round or spindle cells, or of both elements variously intermixed, or, as sometimes happens, combined with giant or myeloid cells, and may, therefore, be classified in accordance with the preponderance of one or the other of these elements, although, from a clinical point of view, it may appropriately be separated into the firm and soft, the latter including the myxomatous and cystic varieties, which differ from each other widely in their progress and in the degree of their malignancy. The circumscribed sarcoma, which is rarely soft, generally forms at the circumference of the gland or in one of the outlying lobules, but presents no features by which it can be distinguished from adenoma or fibroma. It is most common soon after marriage or impregnation, between the ages of twenty and thirty, and evinces little disposition to recurrence. To this tumor certain pathologists apply the name of adenoid sarcoma, but as the glandular structure is not only not of new formation, but often disappears through the compression exerted upon it by the rapidly proliferating new formation, the term should be abolished. The diffused variety of the affection most commonly arises in the centre of the breast, in the neighborhood of the nipple, is composed of small cellular elements, and has a much softer consistence than the circumscribed tumor. It is often combined with cystic dilatation of the milk ducts, the cysts themselves being either barren or filled with solid or semisolid masses of the new tissue. The diffused, soft, medullary neoplasm is most frequent towards middle age, although it has been observed in impubic girls, grows rapidly, but painlessly, attains enormous bulk, undermines the general health, returns after extirpation, and sometimes gives rise to secondary deposits in the pleura, lungs, and other viscera. It is distinguished from encephaloid carcinoma, to which it does not yield in respect to malignancy, by its more rapid development, mobility, greater volume, freedom from suffering and lymphatic involvement, and, as a rule, the absence of marked enlargement of the subcutaneous veins. The cystic form of the affection is not so malignant as the pure medullary tumor, but numerous instances are recorded of repeated repullulation and metastasis to internal organs. Without dwelling upon the general features of these

neoplasms, which are fully discussed in the first volume, it appears to me that the whole subject will be placed in a more satisfactory light by the narration of typical cases of the different forms of sarcoma.

A hearty, robust, married lady, thirty-two years of age, came under my care with a circumscribed, movable tumor, seated deep in the breast above and internal to the nipple. She first noticed it, seven months previously, as a nodule of the size of a pea, which gradually increased, and was the seat of frequent neuralgic pains, which were aggravated in wet weather. After removal it was found to be a globular, deeply-lobed, firm, elastic mass, about one inch in diameter, inclosed in a distinct capsule, and presented, on section, a uniform grayish-white, tough, fibrous structure, which, on minute examination, was found to be composed of a very abundant fasciculated spindle-celled tissue, through which numerous acini and tubules, some undergoing obliteration, were interspersed. The tumor, in fact, was a *fibrous sarcoma*, and has shown no disposition to return, although two years have elapsed since its extirpation.

In striking contrast with the above case is that of a soft, medullary, *small spindle-celled sarcoma*, or fibro-plastic tumor, in which round, oval, and giant elements, however, were present, but not in any great number. It forms, so far as I am aware, the most extraordinary example of recurrence on record, and forcibly illustrates the importance of reëxcision so long as the disease continues to appear at its original site, or, in other words, so long as it retains its local character, and does not infect the general system. The patient, an unmarried female, with small breasts, forty-five years of age, in March, 1857, became affected with a swelling in the left gland, which was partially excised the following October. During the next sixteen months two more operations were performed, and in May, 1859, when the case fell into my hands, I removed the entire breast, along with a fourth tumor. The disease soon reappeared in the cicatrice, and in three months and a half again required the use of the knife. In September, 1861, I performed the twenty-third and last operation, a number having previously been performed by Dr. Asch, one of my former clinical assistants. Altogether fifty-two tumors were removed; all of a soft, spongy, brain-like consistence, very vascular, and from the size of a small almond to that of a pullet's egg. They generally recurred at or near the former cicatrice, within a few weeks after extirpation, and speedily assumed a fungating disposition, with a thin, fetid discharge, but no disposition to bleed. There was little or no local suffering; the woman's general health was all along excellent; there was no lymphatic involvement; menstruation was going on well; and she always rapidly recovered from the effects of the use of the knife. Upwards of ten years have now elapsed since the last operation, and, thus far, the cicatrices are all in a sound condition, soft, and of a whitish aspect.

Small round-celled sarcoma of the breast usually runs a very rapid course, and must be regarded as the most malignant of all neoplasms in this situation, not even excepting encephaloid carcinoma, to which it bears a most striking resemblance in its gross appearances as well as in its clinical history, but from which it may be distinguished by the features already alluded to and by its minute structure. It grows very rapidly, attains enormous bulk, and finally softens, ulcerates, and protrudes fungous masses, liable to frequent hemorrhages. Local and general infection commence early; recurrence after extirpation is almost invariable; and the entire duration of life sometimes does not exceed six or eight months. In the case of a lady, thirty-five years of age, whom I saw with Dr. Addinell Hewson, a tumor of this kind attained, in the course of four months from the time of its first appearance, a weight of nearly six pounds and a volume equal to an ordinary adult head, its basal circumference being twenty-three inches. To the touch it was elastic and movable, its surface was bosselated, and at one point, where the integument was stretched and discolored, there was an indistinct sense of fluctuation. There was no lymphatic involvement, the subcutaneous veins were not enlarged, the nipple was natural, and the suffering, which interfered with her rest, was ascribable to the tension and weight of the growth. Microscopic examination of the soft, pulpy, medullary mass, disclosed an exquisite example of small round-celled tissue, the intercellular substance being amorphous. At several points it had undergone softening and cystoid degeneration, the cavities being occupied with mucoid contents. Two months subsequently the disease recurred in the cicatrice, and in six weeks, when it was of the volume of a small fist, it was again removed by Dr. Hewson. The patient soon afterwards was seized with the most violent and obstinate sciatica; rapid emaciation ensued; another

tumor formed at the cicatrice between nine and ten weeks after the second operation; and she succumbed one month later, apparently exhausted by the combined effects of neuralgia and loss of sleep. The entire duration of life from the first manifestation of the disease was hardly nine months. No post-mortem inspection of the body could be obtained.

Cystic sarcoma, which is of comparatively common occurrence, and an entirely distinct affection from cystic fibroma, previously described, but analogous to cystic sarcoma of the testicle in its mode of production and clinical history, is characterized by the presence of numerous cysts, due to dilatation of the lactiferous ducts, a portion of which has been compressed by the rapidly proliferating interstitial new formation. The cysts are either occupied with fluid, or, as more frequently happens, filled with papillary, foliated, or other forms of solid masses of the new growth, thereby giving rise to proliferous cystic sarcoma in the strict acceptation of the term. The tumor, thus constituted, is most common in middle-aged subjects, is capable of attaining colossal dimensions, its outline is usually irregular and lobulated, while its consistence is unequal, distinct fluctuation, perhaps, being apparent at some points. Its progress is slow, but, after it has acquired a certain bulk, it increases rapidly, softens, ulcerates, and throws out fungous masses. When it is composed of a soft, round-celled basis, the danger of return after extirpation, numerous instances of which are on record, and of infection of internal organs, is much greater than when it is of a fibrous nature. In 1871, I removed a proliferous cystic fibro-sarcoma of the breast of a lady, forty-eight years of age, who had first noticed a small lump, above and external to the nipple, fifteen years previously. Latterly the swelling had increased rapidly, but it was free from pain, and only inconvenient from its bulk and weight. To the touch it was uniformly smooth, firm, and somewhat elastic, except towards its axillary margin, where it was lobulated, with an obscure sense of fluctuation, and an attenuated and discolored state of the integument. It was perfectly free from adhesions; there was no lymphatic involvement in the axilla or elsewhere; and the subcutaneous veins were greatly enlarged. When cleared of fat, the mass, which was finely and largely lobulated, and contained in a distinct capsule, weighed four pounds and a half, and was of the volume of a child's head. The section, which was attended with the escape of a straw-colored, viscid fluid, disclosed a smooth, succulent, glistening, striated, yellowish-white structure, with numerous points of gelatinous-looking substance, which was composed of fibrous tissue in various stages of development, and rich in spindle cells. Interspersed throughout it were dilated acini, lined with cylindrical epithelium, around which the spindle elements were very abundant. This rapidly growing tissue had projected papilliform, polypoid, lobulated, dendritic, and cauliflower-like masses into the dilated ducts, which were of a tough consistence, and either of a yellowish-white or of a gelatinous appearance. The majority of the vegetations displayed the same minute features as the main growth, with the addition, at rare intervals, of small patches of gland tissue. Others were composed almost entirely of white, wavy fibrous tissue, while those which had a gelatinous look showed spindle cells, with oil globules and granular matter. The cysts formed by the distended milk ducts were for the most part single, of large size, many being of the capacity of a hen's egg, and filled with the solid vegetations, the remainder being occupied by a straw-colored or pinkish mucoid fluid. The similarity of the mass in its gross features to the proliferous fibroma, previously described, was most striking. The patient remains perfectly well, fifteen months having elapsed since the operation.

Of *myxomatous and pigmentary sarcoma*, I have never seen any examples in the mamma. They do not, however, differ in their clinical history from the soft, medullary form of the affection, and, like it, may be combined with cystic growths, the dilated lactiferous ducts being filled with the new formation, and thus giving rise to a variety of cystic sarcoma. The presence, in the one, of a net-work of anastomosing cells in a gelatinous tissue, and, in the other, of round or spindle-celled elements impregnated with melanin, suffices to distinguish them from other tumors.

The *treatment* of sarcoma of the breast is conducted upon the same principles as that of carcinoma. The only remedy is the knife, carried far beyond the apparent limits of the disease, and the sooner it is resorted to the better will be the chance of prolonging life and even of effecting a radical cure. In the fibrous and large spindle-celled tumors, local recurrence, much less secondary internal formations, is

not to be anticipated, and the same is true, in great measure, of cystic fibrous formations, although the prognosis in these cases is not so favorable. In the other forms of the affection relapse may be expected, but even in these cases the patient should not be thought beyond the pale of surgical interference, particularly if the tumor be of slow growth, and occurs at an early period of life.

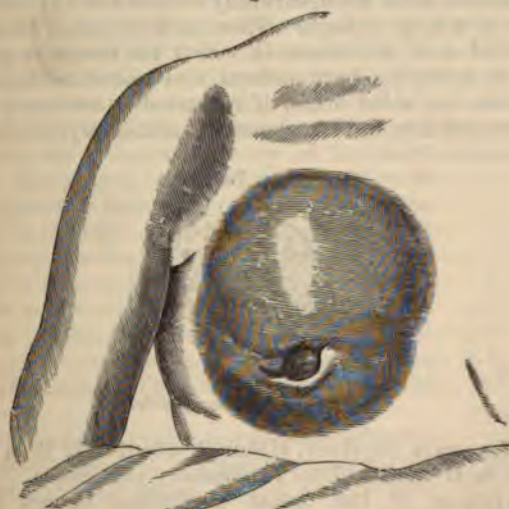
2. SCIRRHUS.

Scirrhus of the breast is most common soon after the decline of the menses, in married females. The average age in 153 cases analyzed by Mr. Sibley, was 48.6 years. It is extremely rare before the age of forty. I have repeatedly seen the disease after seventy. Sir Astley Cooper met with an instance at eighty-six. On the other hand, it may occur at a very early period. The youngest case I have ever seen was in a woman of twenty-seven. Carmichael saw scirrhus in both breasts in a girl of twelve; and Everard Home relates an instance in which it began at the age of fifteen.

Unmarried females occasionally suffer from it, but much less frequently, relatively speaking, than women who have borne children. Its origin is generally spontaneous, although it is often referred by the patient to the effects of a blow or some other external violence. It has been known to occur in four or five members of the same family, and occasionally it coexists with scirrhus in other parts of the body. Now and then it arises in the mammary gland of the male. The disease is usually confined to one breast, and the left suffers more frequently than the right. When both glands are affected, the attacks are always consecutive, never simultaneous.

The affection occurs in two varieties of form, the tuberos and the infiltrated. The former usually begins insidiously, in the axillary border of the gland, as a small circumscribed lump, hard and irregular to the touch, and somewhat tender on pressure. As the disease progresses, the whole organ becomes involved, assuming a firm and knobby character, movable, and the seat of occasional pain, of a sharp, lancinating, darting nature. Advancing still farther, the tumor gradually contracts adhesions to the surrounding parts, especially to the pectoral muscle, so that eventually it can no longer be lifted up, or pushed about. In the mean time the

Fig. 704.



Retraction of the Nipple in Scirrhus.

Fig. 705.



Scirrhus Tumor of the Breast, exhibiting a section of the retracted Nipple.

nipple is retracted; the skin is puckered and discolored; the superficial veins enlarge, and assume a deep bluish tinge; and presently ulceration sets in, leaving one or more circular sores, with hard, depressed, angry-looking edges, and a foul, sloughy base. The discharge is thin, ichorous, offensive, and often so acrid as to erode the healthy skin. Gradually the irritation extends to the neighboring lymphatic glands, which either become white, firm, and tumid, or they are rendered preternaturally soft and vascular, having often a bloodshot appearance.

The retracted appearance of the nipple is well shown in fig. 704, from a patient at the College Clinic. It often begins early in the disease, and is produced by the manner in which the lactiferous tubes are compressed by the scirrhus matter, an effect admirably exhibited in fig. 705.

Although scirrhus generally commences in the very substance of the mamma, yet occasionally its primitive seat is in the common integument or in the surrounding cellulo-adipose tissue. In the former case it usually presents itself as a small, rounded tubercle, scarcely larger than a shot, of a bluish color, firm, superficial, movable, and free from pain. This, gradually increasing, finally involves the glandular structure, the skin, meantime, becoming hard, discolored, and intimately adherent to the subjacent parts. In the other variety of the disease, a firm, oblong, spherical lump, of considerable volume, is from the first felt deeply imbedded in the adipose tissue around the organ, with the latter of which it has apparently as yet no connection. It may readily be lifted away with the thumb and finger, but it soon contracts adhesions, gradually contaminates the adjacent structures, slowly approaches the surface, and at last breaks out into a foul, irritable, fungous ulcer.

The infiltrated variety of scirrhus may begin, first, in the interlobular connective tissue of the gland, forming hard, ill-defined radiating masses gradually lost in the surrounding structures; or, secondly, around the lactiferous tubes, near the nipple, which is soon remarkably retracted in consequence.

On dissection, the mamma is found to be inelastic, firm, dense, and crisp, like cartilage, which it also resembles in color; sometimes it is of a dry, fibrous texture, like the interior of an unripe pear, and of a light grayish tint, interspersed with yellowish lines, probably the remains of lactiferous ducts; more rarely the organ is soft and succulent, presenting a considerable number of small vessels, and yielding, upon pressure, a thin, opaque, serous fluid, occasionally blended with milk. These appearances frequently occur together, forming so many zones, gradually and insensibly running into each other. In some instances, again, the tumor contains one or more cavities, filled with purulent matter, or with a viscid, ropy fluid, not unlike the synovia of the joints. A very characteristic appearance is the concavity presented by the cut surfaces on section.

The volume of a scirrhus breast is extremely variable. When the patient is very fat, the tumor is generally proportionately large, owing to the presence of an extraordinary quantity of adipose matter. The morbid mass itself, carefully divested of extraneous substance, seldom exceeds the size of a large orange. There is, however, a form of the disease, known as *atrophic scirrhus* of the breast, in which the tumor is generally not larger than a small walnut, including both normal and abnormal tissues, which appear to be shrivelled up into one solid mass, of remarkable hardness and density. It is most common in advanced life, and often remains stationary, or nearly

Fig. 706.



Scirrhus Mamma laid open to show its Lobulated Structure.

Fig. 707.



Section of a Scirrhus Nodule.

so, for years together, although eventually it is not less fatal than ordinary mammary carcinoma.

Atrophy of the breast sometimes occurs very rapidly, as in the course of a few months, and that, too, occasionally when the organ has been of unusually large bulk. The wasting process, under such circumstances, seems to involve every portion of the

diseased gland simultaneously, and to proceed in a steady and persistent manner until the organ is reduced to the merest nodule, hardly the size of a common hickory-nut. The malady, as already stated, usually commences in a few lobules; but, as it progresses, the whole organ is converted into a firm, solid mass, with a rough, tuberculated surface. In the annexed sketch, fig. 706, taken from a specimen in my

cabinet, a large number of nodules are seen, the largest of which, hard and crisp, like cartilage, and of an oblong, spherical shape, scarcely equal the size of a pullet's egg. Fig. 707 exhibits a section of one of these bodies.

Scirrhus of the breast sometimes remains quiescent for a considerable length of time, when, taking, as it were, a fresh start, it rapidly assumes the characters above assigned to it. When removed, it is almost certain eventually to return, either at the cicatrice, or in the contiguous lymphatic glands. The tumor is occasionally invaded by gangrene, even before ulceration has commenced. In a case of this kind which came under my observation a few years ago, and which is described in the chapter on the general history of scirrhus, the morbid growth was lifted completely out of its bed, the cavity being afterwards filled up with healthy granulations, although the disease returned subsequently in the neighborhood of the original affection and proved fatal.

The symptoms of scirrhus of the breast are usually characteristic. Its lump-like origin in the body of the organ, its slow but steady progress, the great hardness and comparatively small volume of the tumor, the sharp, lancinating pain, the retraction of the nipple, the gradual adhesion of the breast to the surrounding structures, and the ultimate involvement of the neighboring lymphatic glands, as those of the axilla and subclavicular region, are phenomena which it is impossible to misinterpret. The nature of the scirrhus ulcer is also peculiar. It has an excavated appearance, as if a portion of the tumor had been punched out, with a foul bottom, and steep, everted edges. The discharge is thin, sanious, fetid, irritating, and more or less abundant. Hemorrhage sometimes occurs, but seldom to any extent. Retraction of the nipple generally exists in a marked degree, and often begins at an early period of the complaint. Along with this there is nearly always a deep groove or gutter around the base of the nipple, a sign which, like the retraction itself, is almost characteristic of the nature of the disease. Enlargement of the lymphatic glands, seldom present before the end of the sixth or seventh month, is commonly very conspicuous after the occurrence of ulceration, especially in the axilla. In the more severe forms of the disease, it generally affects those also of the subclavicular region and even those of the neck. Swelling, pain, and numbness of the corresponding extremity always attend the malady in its latter stages, and greatly augment the suffering, the limb becoming perfectly stiff and useless, and feeling like a mass of lead. This occurrence, according to my observation, is most frequent in women who have experienced a relapse after excision of the breast, and is then apt to be proportionately severe. The swelling and hardness generally involve the entire limb, from the top of the shoulder to the tips of the fingers, and greatly intensifies the patient's suffering. I lately attended an elderly lady who had had two operations performed for her relief, and whose limb, enormously increased in size, was for nearly six months a source of the most distressing pain, weight, and numbness. The immediate cause of this condition is the pressure that is exerted upon the veins and lymphatic vessels by the enlarged axillary glands.

The annexed drawing, fig. 708, taken from a clinical case, exhibits the condition of a scirrhus breast in the advanced stage of the disease, after the occurrence of ulceration. The tumor was of unusual volume.

The general health is variously affected. In most cases it remains comparatively good until ulceration begins, when it usually rapidly declines, the body becoming emaciated, and the countenance exhibiting that peculiar sallow, cadaverous appearance, so denotive of the carcinomatous cachexia. The pain, in the latter stages of the disease, is generally atrocious, depriving the patient both of appetite and sleep.

Fig. 708.

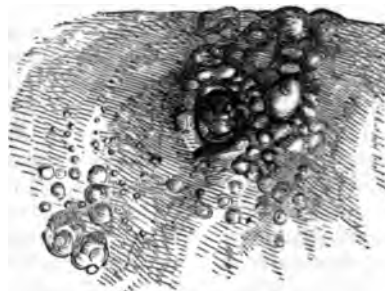


Ulceration of a Scirrhus Breast.

The duration of the disease is far from being uniform. Left to itself, it generally terminates fatally at a period varying from eighteen months to two years and a half. Occasionally death takes place much sooner; and, on the other hand, instances occur in which it does not destroy life under ten, fifteen, twenty, or even twenty-five years, although such an event is extremely uncommon. When ulceration has once fairly begun, the health is rapidly undermined, and the patient usually perishes in a few months. The immediate cause of this event is either sheer exhaustion from excessive pain, loss of sleep, and want of appetite, or pneumonia, hydrothorax, or pulmonary œdema. The most rapidly fatal cases generally occur in young females. Roux met with an instance in which death took place in three months from the commencement of the attack. In old women the disease often remains quiescent for many years, especially when the tumor is uncommonly small.

During the progress of the disease secondary scirrhus growths sometimes appear; generally in the skin and cellular tissue of the breast, or in the parts immediately around, in the form of tubercles, varying from the volume of a small shot to that of a pea, exceedingly firm and solid, slightly movable, very tender on pressure, and the seat of sharp, pungent pain. They often exist in large numbers, as in fig. 709. In one case I counted upwards of fifty. Occasionally they occur both over the mammary gland and at some distance from it. In an instance recently under my care, in a female upwards of fifty, whose breast had been the seat of an enormous scirrhus, of nearly two years' standing, tubercles of this kind appeared a few weeks before death upon the corresponding side of the trunk near the spine, shoulder, neck, and head, and also upon the upper part of the opposite arm. Sometimes these secondary formations show themselves upon the scars left by the bites of the leeches applied for the relief of the pain and of the inflammation of the

Fig. 709.



Secondary Scirrhus Nodules.

breast, as in a case under my charge not long ago in a woman, forty years of age. She had labored under scirrhus upwards of a year, when nine leeches were applied, the bites of which became affected in this way. As these secondary growths increase in size, they project beyond the skin, and exhibit a red, vascular, angry appearance, denotive of the worst consequences, and, of course, imperatively forbidding surgical interference.

A very singular condition of the common integument, consisting in a dark-colored, brawny alteration, occasionally occurs in the latter stages of scirrhus, both upon the breast and in the parts immediately around it. The induration is generally very great, the skin feeling as hard as marble, and there are cases in which it is accompanied by a remarkable contraction of the affected structures, not unlike what is so often witnessed in the scars of burns and scalds. The cause of this change, which sometimes involves a large portion of the chest, reaching, perhaps, as high up as the clavicle and shoulder, and finally extending down even over the arm, is the infiltration of carcinomatous cells, converting the skin and subcutaneous cellular tissue into a substance of the color and consistence of the rind of bacon. Hence it is generally known as the lardaceous degeneration of the skin. Its presence is always denotive of a highly vitiated condition of the system, with a rapid downward tendency.

Cases, again, occur in which the skin over the indurated gland exhibits a peculiar striated appearance, the individual lines extending outwards from the nipple like so many radii. The appearance is evidently due to distention of the lymphatic vessels by carcinomatous material, and is a sign of unusual malignancy. In the more severe forms of the disease thus characterized, the surface is raised into numerous hard, whitish ridges, higher at some points than at others, and so closely aggregated as to render the tissues as firm and inelastic as a board. I have repeatedly witnessed this injected condition of the cutaneous absorbent vessels at a very early period of scirrhus. In a case recently under my care, one of the best marked of the kind I ever saw, the patient was only thirty-five years old.

3. ENCEPHALOID.

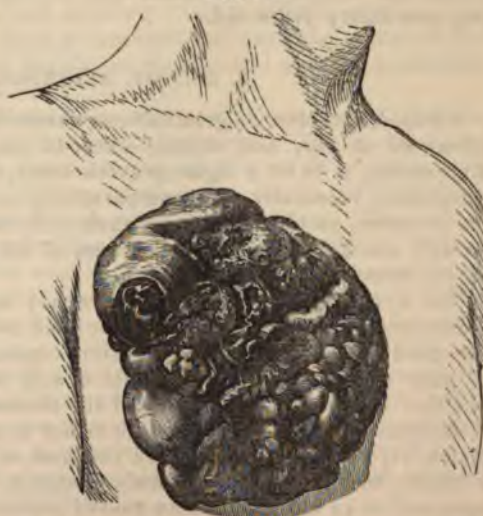
In comparison with scirrhus, encephaloid of the mamma is a rare disease. Of 54 cases analyzed by Velpeau, 36 occurred between the fortieth and sixtieth years, and most of the cases that have fallen under my personal observation happened in elderly subjects. I have, however, repeatedly met with it before the age of thirty-five, and in one instance in a girl of fifteen. At least one example of encephaloid of the mamma, of the most acute character, has been witnessed at the age of eighty-two. Of its relative frequency to encephaloid in other organs, it may be stated that of 100 cases of the disease analyzed for me by Dr. Cassot, only 6 occurred in the breast, the eye being affected in 10, and the scrotum and testicle in 14.

It is not possible to tell with any degree of exactitude the proportion which the cases of encephaloid bear to those of scirrhus. Professor J. B. S. Jackson asserts that it is not less than one-fifth; but this does certainly not accord with the results of my observations. I have seen a large number of cases of carcinomatous breasts, and I am quite sure that at least nineteen-twentieths of them were examples of scirrhus. Soft carcinoma of the mamma appears to be much more common in France and Germany than in England, where, according to Paget, it occurs in the ratio only of about five to ninety-five.

The symptoms are commonly well marked. Ordinarily the disease begins, without any assignable cause, as a small tumor in the substance of the gland, which generally increases with frightful rapidity, often acquiring the bulk of a large fist or even of a foetal head in the course of a few months. Like scirrhus, it is at first movable, but eventually it is firmly united to the surrounding structures, which it is sure, in time, to involve and contaminate. The pectoral muscle, in particular, is liable to suffer in this manner. The lymphatic glands, however, generally escape longer, comparatively speaking, than in hard carcinoma, and I have seen cases in which, although there was extensive ulceration, they were entirely free from disease. Moreover, the subclavicular and cervical glands are less liable to suffer than in scirrhus. The tumor is usually knobby or tuberculated, and of varying degrees of consistence, being firm and incompressible at one point, soft at another, and perhaps fluctuating at a third. There is seldom any marked retraction of the nipple, even in the advanced stages of the malady. The subcutaneous veins are always greatly enlarged; the pain is comparatively slight; and the parts are generally singularly tolerant of manipulation. Ulceration sets in at variable periods; rarely before the ninth month or later than the twelfth. The resulting sore is peculiar. Its character is essentially that of a fungus, projecting beyond the surrounding level, soft, red, and the seat of more or less bleeding, and of a constant sanious, or thin, fetid, and sanguinolent discharge. The edges of the ulcer are sharp and undermined, and often drawn tightly over the protruding mass. Like the scirrhus ulcer, the encephaloid is intractable; its tendency is to spread, not to heal, neither having the power of forming healthy granulations. The external characters of the fungating and bleeding stage of the disease are well shown in fig. 710.

The general health usually suffers at an early period; the patient loses flesh and strength, and the countenance exhibits a sallow, withered appearance, denotive of the profound impression which the disease is making upon the system. The pulse is small, frequent, and irritable, the appetite fails, sleep is interrupted by the pain and the discharges, night-sweats set in, and thus the case steadily progresses, from bad to worse, until life is worn out by exhaustion.

Fig. 710.



Encephaloid of the Mamma, in its Open, Bleeding State.

Sometimes the immediate cause of death is hemorrhage. In some cases the patient perishes from hydrothorax, pneumonia, pleurisy, or pulmonary œdema. The period at which life is worn out varies, on an average, from six to twelve months.

The diagnosis of encephaloid is, in general, too well marked to admit of error, especially if the disease has taken a fair start. The great size, rapid growth, and comparative softness of the tumor, the healthy condition of the nipple, the enormous enlargement of the subcutaneous veins, the absence for a long time of severe pain, and the early constitutional involvement, will always serve to distinguish it from other carcinomatous diseases of the mammary gland. When, however, any doubt exists as to the diagnosis, as there may when the tumor has been developed with extraordinary rapidity, or when it presents well-marked evidence of fluctuation, the exploring needle may be used; of course, with great caution. After ulceration has begun, error is impossible.

The anatomical characters of encephaloid of the breast do not differ from those of soft carcinoma in other organs of the body. The structure of the tumor is seldom uniform, either as it respects its consistence, color, or composition. Thus, on making a section of it, one portion may, perhaps, be of a fibro-cartilaginous character, another pulpy and brain-like, and a third,

probably, hematoid, or cystiform. Cavities or cells, containing different kinds of fluids, are often interspersed through it. Large clots of blood, of a black, brownish, or yellowish-buff color, and varying degrees of consistence, are also sometimes met with. The tumor has no capsule, except what is derived from the surrounding connective tissue, which is occasionally considerably condensed; the surface is rough and lobulated, and its substance is usually pervaded by numerous vessels, many of them of large size. Hence the rapidity of its growth, its large bulk, and the frequent and exhausting hemorrhages after ulceration has commenced. It sometimes coexists with encephaloid or scirrhus in other organs. Fig. 711 affords a good idea of the hematoid form of encephaloid of the mamma. The tumor from

Fig. 711.



Encephaloid of the Mammary Gland, of the Hematoid Variety.

which the drawing was taken was of very large size, and removed by me from a negress, thirty years old.

4. COLLOID, MELANOSIS, AND EPITHELIOMA.

Colloid, alveolar, or gelatiniform carcinoma rarely attacks the breast. The tumor advances slowly, and seldom exceeds the volume of a fist or of a foetal head. Externally, it is of a light grayish color, dense, firm, glistening, and irregularly lobulated; internally, it is comparatively soft and succulent, yielding some moisture on pressure, and tearing into hard, jelly-like strings. The alveolar arrangement, so well marked in colloid carcinoma of the stomach, is seldom very distinct in that of the breast.

The symptoms of the disease are not sufficiently characteristic to admit of its identification prior to the removal of the morbid mass. The most reliable signs are, the gradual increase of the affected organ, the concomitant hardness, the absence of pain and tendency to ulceration, and the unimpaired condition of the general health. To prevent recurrence of the disease, the entire breast should be extirpated.

Melanosis of the breast occurs either as an infiltration between the lobules of the gland, or, as is more frequently the case, in the form of small, spherical nodules, of a black, sooty color. The only instance of this disease that I have ever seen occurred in an old female who died of pulmonary phthisis, accompanied with scirrhus of the left mamma. The little tumors, five in number, were distinctly encysted, and contained a thin, ropy fluid, of the color and consistence of India ink.

Epithelioma of this organ is so extremely uncommon that the very possibility of its occurrence has been denied by some of the most able pathologists. The cases, however, reported by Billroth and other observers seem to leave no doubt upon the

subject. The disease originates in the glandular epithelium and is capable of forming a mass of large size. The growth presents no features by which it can be distinguished from other affections of this organ.

TREATMENT.

The treatment of carcinoma of the breast naturally divides itself into medical and surgical, or, in other words, into palliative and radical. The medical, again, resolves itself into constitutional and local.

The great object of the constitutional treatment is simply to maintain the general health as nearly as possible at the natural standard. The more successfully this can be done the more likely will the case be to progress favorably. The best means for fulfilling this indication are, a proper regulation of the diet, bowels, and secretions, the avoidance of pain, and an abundance of sleep, with an equable, contented state of mind.

The most appropriate diet, in my judgment, for a carcinomatous patient, is that which best agrees with the stomach and affords the most abundant supply of wholesome nourishment in the smallest compass. Everything that tends to provoke flatulence and indigestion should be carefully avoided. If the woman is plethoric, the food should be principally of a farinaceous character, with weak tea or milk at breakfast and supper; if, on the contrary, she is thin, pale, and feeble, more or less meat will be required, and the most suitable articles are boiled fish, oysters, lamb, and poultry. In addition to a nutritious diet, the case may be such as imperatively to demand the moderate use of ale, wine, brandy, or milk punch.

The bowels should be constantly maintained in a soluble condition; but everything like active purgation must be avoided. Any tendency to disorder of the secretions must be counteracted with blue mass, or a small quantity of calomel, given at bedtime and carried off in the morning with a little magnesia or Rochelle salt. As an habitual laxative nothing answers better than Plummer's pills. Flatulence and acidity must be corrected with alkalies; nausea with champagne and aerated water; derangement of the menstrual function with emmenagogues.

Pain is allayed by anodynes, as morphia, opium, black-drop, or deodorized laudanum, in doses suited to the exigencies of the case. When the skin is hot and dry the best article is Dover's powder, either alone or combined with opium and a few grains of blue mass, to prevent the medicine from drying up the secretions. A hypodermic injection of a third to half a grain of morphia towards bedtime usually insures a comfortable night's rest.

Sleep must be secured at all hazard; and nothing will contribute more to the comfort and well being of the patient than a tranquil and resigned state of the mind. Change of air and scene is often highly beneficial; and sometimes marked relief follows a residence at the sea-coast.

As it respects internal remedies, all ideas of specifics must be banished, and the case managed upon general principles, as in any other disease. The accumulated experience of two thousand five hundred years has proved that all attempts to cure carcinoma of the mammary gland and of other organs, by means of medicines, however well directed or perseveringly continued, are perfectly futile. They often, however, do good by improving the general health, and on that account deserve careful consideration. The most valuable articles are the different preparations of quinine, bark, and iron, either alone or variously combined. Arsenic is also a useful agent, and perhaps the best form in which it can be given is the iodide, in the dose of one-sixteenth of a grain thrice a day. Fowler's solution is objectionable, on account of its tendency to produce anasarca and dropsical effusions. Cicuta, sarsaparilla, iodine, mercury, alkalies, acids, cod-liver oil, and iodide of potassium, so frequently employed in this disease, possess no particular virtues either in modifying its action or in arresting its progress. As to venesection, it may be of benefit when extraordinary plethora is associated with excessive pain and great local excitement; but, in general, it could hardly fail to be injurious.

The topical treatment is of great importance. The affected organ should be carefully suspended, and all sources of pressure removed. If inordinate vascular excitement exist, from six to a dozen leeches should be applied, especially if the patient is plethoric, and the flow of blood encouraged for some hours with cloths wrung out of warm water. Afterwards the parts may be kept constantly wet with a strong solu-

tion of acetate of lead and opium, or Goulard's extract and laudanum. Sometimes a light emollient poultice, medicated with these articles, exercises a very soothing influence, and, in many cases, marked relief follows the use of the dilute tincture of iodine, containing from eight to ten grains of morphia to the ounce. Anodyne plasters are generally extremely beneficial; but, to answer the purpose, they should be well spread, carefully applied, and free from irritating matter. The best are those made of opium, cicuta, stramonium, and belladonna. The soap, compound galbanum, and DeVigo's plaster are also useful applications, especially if well sprinkled with morphia.

Systematic compression, formerly so much vaunted, is utterly useless, except now and then in the early stage of scirrhus, when it may assist in relieving pain and retarding growth. It may be applied with Tanchou's spring pad, an instrument constructed upon the principle of a truss, an Arnott's air-cushion, or, what is better than either, prepared sponge and a roller. As a curative agent it is perfectly worthless, as I can testify from repeated and faithful trials.

When ulceration arises, the leading indications are to moderate discharge, prevent hemorrhage, mitigate pain, allay fetor, promote cleanliness, and sustain the strength. The objects may, in general, be readily fulfilled by means of soothing applications, subsulphate of iron, anodynes, Labarraque's solution or permanganate of potassa, frequent ablutions, and a nourishing diet with milk punch. When copious hemorrhage ensues, and it cannot be checked by the usual hemostatics, it may be necessary to resort to acupuncture, especially if the blood issues from an artery or vein of considerable size.

The excessive swelling of the arm on the affected side, which is often a source of such great distress in the latter stages of the disease, is best controlled by careful compression with the roller, and steady elevation of the limb. Punctures will rarely be required, and should, if possible, be avoided, as they might be followed by ulceration and even gangrene. Dilute tincture of iodine is sometimes beneficial. Itching of the skin may be relieved by zinc ointment or Goulard's extract.

By means of these measures, judiciously employed, the patient may often live in great comfort for months and even years. Gradually, however, the vital powers give way, the countenance assumes the peculiar sallow expression, so indicative of the carcinomatous cachexia, and she finally expires in a state of complete exhaustion.

In regard to the use of the knife, as a means of relief in carcinoma of the breast, the greatest possible contrariety of opinion exists. While some are altogether opposed to it under any circumstances, there are others who do not hesitate to resort to it in every case, and at almost every stage of the disease, either as a curative or as a palliative measure. They argue that it is better to operate even if it afford only temporary relief, than to abandon the patient to her fate; and, on the other hand, they positively assert that extirpation is occasionally followed by a complete cure, or, if not a complete cure, by such a protracted immunity from disease as virtually to amount to that.

It has been a question with surgeons whether extirpation of a carcinomatous breast does, on an average, tend to shorten or prolong life. The subject has been examined by different observers, but the only reliable statistics, so far as I know, are those that have been supplied by Sibley and Paget. The former of these writers finds that the average duration of life in primary scirrhus of the breast, allowed to pursue its natural course, was 32 months, whereas in those subjected to the knife it amounted to 53 months, thus showing a difference of 21 months in favor of the latter. In Paget's cases the unoperated afforded an average of 43 months, and the operated of 57½. The effect of the removal of medullary carcinoma is less propitious. The disease always proves more rapidly fatal than scirrhus, whether it be let alone, or whether it be subjected to the knife.

In all calculations of this kind there must necessarily be many sources of fallacy, more or less influencing the result. Among these, not the least is the difficulty of tracing such cases to their final termination. My experience is that the average duration of life, in unoperated cases of scirrhus breast, does not afford nearly as high an average as that given by Paget. It approaches much nearer that of Sibley. The statistics of both are on too limited a scale to entitle them to much practical weight.

The age at which the malady appears exerts a marked influence upon the duration of life. Thus, Paget, in his tables, finds, that, of those who lived only eighteen months,

the carcinoma commenced at 43 years; of those who were spared from eighteen to thirty-six months, at 51 years; and of those who survived from three to eight years, at 56 years.

That excision of a carcinomatous breast, both in the soft and hard varieties of the disease, may greatly prolong life, if not actually lead to a radical cure, is unquestionable. That the instances, however, are rare, and, therefore, exceptional, is equally true. Velpeau, in 1834, extirpated an encephaloid breast, of the size of a child's head, and, in 1853, when he last saw the patient, the parts were perfectly sound. The tumor, at the time of the operation, was in an ulcerated, fungous condition, and the seat of an ichorous, bloody discharge, latterly attended with occasional hemorrhage. The diagnosis was unmistakable. In a case communicated to me by Dr. J. Mason Warren there was no relapse at the end of six years. The woman was sixty-nine years of age, and the tumor, a specimen of pure encephaloid, weighed nearly three pounds. I am cognizant of an instance of a similar kind, in which there was no return at the end of seven years, the woman in the meanwhile having given birth to two children. The diagnosis was attested by a microscopical examination of the morbid structure.

The records of surgery supply us with a considerable number of examples of scirrhus of the mamma in which no relapse occurred for a number of years. Dr. J. C. Warren met with four cases in which the patients survived the operation, and finally died of some other malady, respectively, 19, 21, 22, and 33 years. Brodie refers to two instances of 14 and 16 years. Velpeau saw one of 12 and another of 27 years. Physick gives a case of 9 years; Mussey of 10; Paget of 11½.

These, again, are all exceptional cases; and opposed to them is the melancholy fact, familiar to every surgeon of experience, that relapse, as a general rule, promptly follows all operations of this kind, however early or skilfully executed. A return of the disease is inevitable; a mere matter of time, sooner in some cases, later in others. No surgeon can with any certainty specify the period. I doubt whether in the majority of instances it exceeds five or six months; some do not reach half that period; and very few go beyond a year. In one of my cases the malady recurred in less than three weeks, notwithstanding the most patient and thorough dissection, and the most assiduous attention during the after-treatment. The woman, aged forty-four years, the subject of scirrhus for eight months, died in great agony three months after the operation.

If it were possible to credit the statistics that were published in the latter part of the last century and in the early part of the present by Hill, Nooth, and others, we should be compelled to conclude that the extirpation of carcinomatous breasts was one of the most successful of operations. The former of these writers announced, in 1770, that he had had, up to that time, 88 cases, of which 40, whose breasts had been removed upwards of two years, were then alive and sound. In 9 cases the disease had broken out afresh, 2 were not cured, and in 1 a relapse was threatened. The results of the operations of Nooth, as given in his work on Cancer of the Mammary Gland, seem to have been still more favorable; for of 146 cases only five are reported as having been unsuccessful!

On the other hand, Dr. Monro, of Edinburgh, in 1742, asserted that he had witnessed nearly 60 cases of excision of carcinoma of the breast, and of these only 3 remained free from the disease at the end of two years. Dr. John Macfarlane, in 1838, published the results of 32 cases that had occurred in his own practice, and in not one of which the cure was permanent. Of 86 additional cases, communicated to him by different surgeons, the issue was equally unfortunate; and the same is true of the cases, 98 in number, reported by Professor Benedict, of Breslau. In the majority of these cases the knife was used at an early period; the affected structures were most thoroughly removed, and in many of the patients there was no evidence whatever of constitutional deterioration; and yet in every one the malady returned, either externally or internally, and gradually proved fatal.

The results of the experience of Monro, Macfarlane, and Benedict have been fully confirmed by those of a more recent period, and they conclusively show the utter worthlessness of the statistics of Hill, Nooth, and others, who were either bad observers or men of no veracity. To sum up the whole matter, it may confidently be asserted that the knife, if it does any good at all, is only a means of temporary relief, generally, indeed, of a very transient character.

But, although an operation may not often materially prolong life, nay, perhaps

sometimes even do harm in hurrying on the fatal issue, there are, nevertheless, in my judgment, valid reasons for its occasional performance. No one can doubt that in cases strictly exceptional, such, for example, as those previously alluded to, extirpation may be followed by the happiest results, not only ridding the part of pain but enabling the patient to live in entire comfort for many years. That some of these cases would, if left to themselves, terminate fatally much sooner than if subjected to an operation is extremely probable. Who, among a given number of cases, can foretell which may be the lucky exceptional one?

Operative interference, it seems to me, is proper when, as not unfrequently happens, the patient's mind, filled with gloomy forebodings, is in a state of constant depression and despondency. Here the knife acts as a cordial; hope is revived, new life springs up, and, for a while, at least, there is relief from suffering.

Extirpation is occasionally performed simply with a view to bodily palliation, as when the system is racked with pain, and worn out from the want of appetite and sleep. Or, it may be, the patient is rapidly sinking under the effects of hectic irritation and the profuse and foul discharge which so often accompanies an open carcinoma. The very air she breathes is poisoned by the effluvia of her apartment. No one will deny that the removal of a breast, in such an event, would not be proper, even if it should be attended with some risk to life. The tumor is excised; pain and discharge cease; appetite and sleep return; even hope is temporarily revived.

The most promising conditions for a favorable issue, as it respects the prolongation of life, are, the tardy growth of the tumor, the appearance of the disease after the fiftieth year, the partial enlargement of the gland, the normal condition of the nipple, the absence of lymphatic involvement, and the complete integrity of the general health.

No operation should be performed when the tumor is uncommonly small and circumscribed, not exceeding the size, for example, of an English walnut; when the disease, if not entirely dormant, is indisposed to spread; when the carcinomatous action is, to all appearance, strictly local in its origin; when the patient is after sixty or sixty-five years of age; and, finally, when there is no constitutional involvement. The united experience of the profession shows that a female, in such a condition, may live for years—sometimes ten, fifteen, or even twenty—in comparative comfort, and ultimately die of some intercurrent malady.

Interference with the knife is out of the question where there are extensive ulceration of the tumor, great involvement of the lymphatic glands, firm adhesions, secondary formations in the skin or in some internal organ, a hereditary taint, extraordinary rapidity of development, and well-marked evidence of the carcinomatous cachexia. In such an event an operation would only inflict additional suffering upon the patient, and tend to bring surgery into discredit.

The period of *recurrence* after operation varies. The cases most favorable for prolonged immunity are those in which the disease is purely local, where there is no constitutional involvement, where the patient has passed the fiftieth year, and where there is no hereditary taint. Of 74 cases collected by Paget and Lebert, 55 relapsed before the end of the twelfth month, and two-fifths of that number from the first to the third month: 7 lived from one to two years, 3 from two to three, 1 from three to four, 2 from four to six, and 2 from six to eight.

The suffering consequent upon repullulation is said by some highly respectable authorities to be less than when the disease is permitted to pursue its natural course. The statement does not coincide with the results of my experience.

The disease, after removal, in the great majority of cases, returns either at the original wound, in the skin in the neighborhood of the cicatrice, in the axillary, subclavicular or cervical glands, or in some internal structure, as the pleura, lung, liver, or uterus. Reëxcision should be practised so long as the disease continues to appear at its original site; or, in other words, so long as it retains its local character, and does not infect the general system.

Velpeau relates a case of encephaloid of the breast in which he eventually effected a radical cure after three operations, the first having been performed when the woman was fifty-six years old. She remained perfectly well at the end of twelve years. All the tumors exactly resembled each other in structure and appearance. Roux was equally fortunate after six returns of the disease. Professor Knight, of New Haven, extirpated a scirrhus mamma from an old lady, who survived the second operation eighteen years, and finally died at the age of ninety-five.

Finally, I am not an advocate for removing carcinomatous breasts with *caustics*. Independently of the cruel pain which attends and follows their application, there are few cases in which, unless the disease is exceedingly limited, they do not leave more or less of the morbid structures intact, and, consequently, in a condition for speedy outgrowth. The knife is always a more certain remedy, and in these days of anæsthetics there is no valid reason why it should ever give way to escharotics. Some surgeons are favorable to the employment of these substances on the ground that their application is accompanied with less hemorrhage than excision; this may be true, but it is equally true that there never need be much bleeding, however large or vascular the tumor may be, if proper care is exercised in its extirpation.

I do not think, however, that caustics should be altogether condemned in the treatment of carcinoma of the breast; for cases do occur in which they may advantageously be used as palliatives, for allaying fetor and for improving the condition of the ulcerated surface. They are particularly adapted to the latter stages of the disease, when the period for extirpation is past, and when all that can be done is to render life a little more tolerable. The best articles for the purpose are the Vienna paste, butter of antimony, and chloride of zinc, applied while the patient is anæsthetized, and followed, if there be much pain, by a full anodyne.

As to the *écraseur*, as a means of removing a carcinomatous mammary gland, no surgeon who has any self-respect could be induced to employ so barbarous an instrument for such a purpose. I can certainly not conceive of any case that would justify it.

DISEASES OF THE NIPPLE AND AREOLA.

The nipple and areola are liable to inflammation, syphilis, morbid growths, and malignant disease.

Women, during their confinement, particularly if it be a first one, are extremely liable to suffer from *inflammation* of the nipple, speedily terminating in ulceration and constituting what is ordinarily known as sore nipple. The sores have generally the appearance of superficial fissures, cracks or abrasions, attended with a thin, serous, or sero-sanguinolent discharge, and excessive pain, usually of an itching, smarting character. Occasionally the ulceration extends to a great depth, partially separating the nipple from the breast, and thus greatly augmenting the suffering. The affected parts are red and inflamed, the breast feels tender and hard from the accumulation of milk, and the sebaceous follicles around the nipple are irritated and sensibly enlarged. The disease usually appears within the first few days after delivery, in consequence of the application of the child's mouth, which never fails to aggravate it.

The treatment consists in the application of collodion, in thoroughly emptying the breast at least three times a day with the pump, and in the use of an active purgative, along with a light, dry diet, the object being a partial suppression of the milk. If both nipples are affected, the child should be compelled to suck with the aid of a heifer's teat, until the parts are cicatrized. Protection from the pressure of the clothes is afforded by means of an appropriate glass.

When collodion fails to afford relief, various astringent remedies may be employed, as weak solutions of alum, zinc, or copper, in union with tannic acid. Nitrate of silver, in the proportion of two grains to the ounce of water, sometimes answers a good purpose. Yellow wash, prepared with one-fourth of a grain of bichloride of mercury to the ounce of water, makes an excellent application for superficial chaps of the nipple, but caution must be observed in its use. Occasionally nothing affords such prompt relief as the ointment of nitrate of mercury, diluted with eight or ten times its weight of simple cerate. A strong solution of borax, thickened with brown sugar, and rendered stimulating with brandy, is a favorite domestic remedy, from which I have frequently derived great benefit.

In most cases, the foundation of this disease is laid during pregnancy, from a want of proper attention to the parts. In general, all difficulty may be successfully prevented by the avoidance of pressure, and the use of some astringent wash, as alum and tannic acid, for the purpose of hardening the nipple.

The nipple is often very short, imperfectly developed, or flat and retracted, much to the annoyance both of the mother and child. Of the plans that have been suggested for raising it when thus affected, per-
fectual is the appli-

cation of a large bottle with a long neck, in which the air has been rarefied with hot water. The water having been poured out, and the mouth of the bottle placed over the nipple, a vacuum is formed as the bottle cools, which thus establishes a powerful and equable suction, thereby materially elongating the parts without any serious inconvenience to the mother. Most of the suction tubes and pumps, properly so called, do more harm than good in these states of the nipple. This treatment may often be advantageously employed during the last six or eight weeks of pregnancy, so that the nipple may be sufficiently developed by the time of birth.

Syphilis of the nipple may exhibit itself either as a primary or secondary affection, or in the form of a chancre or of a broad condyloma. Chancre may be communicated by a sore or mucous tubercle upon the lip or tongue of the child in the act of sucking, forming an ulcer which exhibits the characteristics of the initial lesion of syphilis upon the genital organs, passing through the same stages, attended with involvement of the axillary lymphatic glands, and followed, eventually, by constitutional symptoms, perhaps of the worst kind. The treatment is conducted upon the same general principles as in syphilitic disease of other tissues.

Tumors of the nipple and areola are of uncommon occurrence, the most frequent being the sebaceous and pendulous cutaneous growths. The *sebaceous* tumor, developed from the glands which are so abundant near the base of the nipple and upon the surface of the areola, is readily distinguished by its tardy development, its superficial situation, its great mobility, its rounded and spherical form, its freedom from pain, and its soft consistence. Russell has described a tumor in this situation which contained a pulsataceous material mixed with hair, and which appears to belong to this category; while Billroth met with a partially calcified atheroma of the male areola of the volume of a hen's egg. A *pendulous* tumor sometimes forms upon the areola, generally in close contact with the nipple, and occasionally even within its substance. It is generally attached by a narrow pedicle, which eventually may acquire a length of several inches. The structure of the tumor, which varies in volume from a cherry to that of a walnut, exhibits nothing of a definite character. In many cases it consists, apparently, simply of a hypertrophied condition of the skin and connective tissue, inclosing a few long, slender vessels. In other cases, more especially when the tumor takes its rise in the nipple, it is composed, in addition to dermoid and connective substances, largely of glandular and papillary matter, the surfaces, in this event, having a reddish, tuberculated aspect, not unlike that of a strawberry. In another class of cases, the morbid growth is mainly of a naevoid structure, consisting principally of enlarged convoluted veins. Finally, the pendulous mass may be composed of myxomatous tissue, as in the rare and interesting case of a female, twenty-one years of age, alluded to by Virchow, in whom the neoplasm, which was of two years' growth and of the volume of the fist of an infant, sprung from a warty excrescence just by the side of the left nipple.

For the sebaceous tumor, the only remedy is enucleation. In the pendulous growths the knife should be carried around the base of the tumor, so as to include a portion of the sound skin. Unless this be done, speedy recurrence will almost be inevitable. Hence, ligation of the pedicle, as advised by some surgeons, is decidedly objectionable.

Of the *malignant* affections of the nipple and areola, by far the most common is epithelioma, of which I have met with several characteristic examples. In a maiden lady, forty-seven years of age, whom I recently saw in consultation with Dr. Stubbs, the morbid action commenced in the form of a hard tubercle in the areola, from which it gradually extended over the whole of the mammary gland. The nipple was remarkably hard and firm, erect, and at least three-quarters of an inch in length. The skin around was occupied by a superficial ulcer, fully the size of the palm of a large hand, and the seat of a thin, sanious, fetid discharge, which had made its appearance about six months previously. The pain was of a gnawing, dragging nature, and so severe at night as to interfere with sleep. The breast, naturally very small, was firmly bound down to the pectoral muscle, and felt like a very hard, solid substance. All the tissues around this organ, as well as over it, were greatly swollen and indurated, from the infiltration of inflammatory new formations and epithelial matter. The lymphatic vessels of the skin had a peculiar knobby appearance, their course being indicated by well-defined purplish lines. Several of the subclavicular lymphatic glands were enlarged, but those in the axilla were per-

fectly sound. The corresponding arm was swollen, œdematous, and of a mottled hue. The general health was good.

Dr. Rogers, of New York, in 1866, reported a case of epithelioma of the mamma, in which the disease originally appeared as a warty excrescence in the skin at the side of the nipple. It rapidly increased in size, and in the course of twelve months attained the bulk of a small orange. The woman was seventy years of age.

DISEASES OF THE BREAST IN THE MALE.

The mammary gland of the male, although merely a rudimentary organ, is liable to the same diseases, benign and malignant, as that of the female, but only, as experience has shown, in very rare instances. The most frequent affections here, according to my observation, are hypertrophy, induration, and neuralgia, which, indeed, are generally associated, and are sufficiently common to render them objects of great practical interest. In 1859, not less than three cases of these diseases were at the same time under my care at the College Clinic, all the patients being young men otherwise in good health. In each the organ was very hard, decidedly enlarged, remarkably tender on pressure, and the seat of sharp, darting pains, liable to frequent exacerbations. Occasionally both glands are involved.

The treatment of these several affections must be conducted upon the same principles as in cases of mammary neuralgia or irritable breast in the female. The result, however, is generally anything but satisfactory; for, although temporary amelioration may soon follow, it is only after a long time, and after frequent relapses, that permanent relief is obtained. The most trustworthy remedies are quinine, arsenic, and strychnia, with a minute quantity of bichloride of mercury, aided by occasional leeching, and the use of sorbefacient and anodyne plasters.

Abscesses sometimes form in the mammary region of the male, either in the substance of the gland immediately below the integument, between the gland and the pectoral muscle, or beneath the latter, especially when the suppuration has been provoked by external violence, as a fall or blow. The diagnosis is generally easy, and the treatment sufficiently obvious.

The breast of the male has been found to be enormously *hypertrophied*, forming a large, heavy mass at the front and side of the chest. It is also occasionally the seat of adenoid, fibrous, cystic, sebaceous, and sarcomatous *tumors*. The sarcomatous growths sometimes ulcerate, throwing out fungous, cauliflower-like excrescences, which, independently of their alarming appearance, are more or less painful, and the seat of a fetid discharge. The proper remedy is extirpation.

Of the *malignant diseases* of the male breast, the most common is scirrhus; encephaloid is very infrequent, and the same is true of melanosis and colloid. Hard and soft carcinomas pursue the same course here as in the other sex; they are most common in elderly subjects, and are generally easily distinguished by their external characters. A well-marked case of open scirrhus of the left mammary gland, in a man, seventy years of age, was recently shown to me by Dr. W. H. Webb. The ulcer was nearly two inches in diameter, very painful, and the seat of a thin, bloody, fetid discharge. Marked involvement of the axillary lymphatic glands existed. Extirpation is always followed by a recurrence of the disease, although usually not so soon as when it affects the female breast.

In a remarkable case of melanosis of the male breast, in a man, eighty-two years of age, kindly communicated to me by Dr. William L. Newell, of New Jersey, the malady had taken its rise near the left nipple, in an old wart-like excrescence, which, in a fit of delirium, the patient had picked off eight months previously to his death. About four weeks prior to this event, the morbid growth had attained the volume of a large fist, and was attached by a pedicle nearly an inch and a half in diameter; it was of a black color, lobulated in shape, and of a soft, brain-like consistence. Ulceration gradually set in, and in a short time the whole tumor sloughed away, followed by a copious, black, and most offensive discharge. Secondary growths now appeared in the neighborhood of the original disease, and one also, about the size of a walnut, at the inferior angle of the left scapula. The whole march of the disease was painless, and the man died from sheer exhaustion, occasioned by the profuse discharge.

I recently saw, in a man, thirty-five years old, a patient of Dr. Cullen, of Camden, New Jersey, a secondary carcinomatous formation in the left mamma, consequent

upon the existence of a large encephaloid tumor of the corresponding axillary lymphatic glands. Numerous subcutaneous carcinomatous tubercles existed upon the abdomen, chest, neck, and shoulders.

DISEASES OF THE BREAST IN THE INFANT.

New-born infants are subject to a peculiar intumescence of the breast, consisting in inflammation of the glandular structure of the organ and of the surrounding cellulo-adipose tissue, the nipple, which is usually a good deal enlarged, forming the centre of the swelling. The part feels excessively hard, and is exquisitely tender on pressure. Under an erroneous supposition that the disease is caused by an accumulation of milk, the breast is often rudely squeezed; a circumstance which never fails to aggravate the morbid action. If improperly managed, suppuration may occur, as I have witnessed in quite a number of cases. Both breasts are sometimes involved. The disease generally appears within the first fortnight; sometimes, indeed, within the first few days, or at so early a period as to induce the belief that it is congenital. As it advances, the part becomes excessively painful, and the child is feverish and restless.

The disease, in its incipient stages, generally readily yields under the use of sweet oil and laudanum with a little ammonia, applied quite warm, and rubbed in frequently with the bare finger. In the intervals the surface should be constantly covered with a thick layer of flannel saturated with a solution of hydrochlorate of ammonia, in the proportion of one drachm to eight ounces of water and two of vinegar. When the disease is obstinate, or already far advanced, a leech may be applied, followed by a teaspoonful of castor oil. In the event of suppuration, an early puncture is made.

AFFECTIONS OF THE MAMMARY REGION.

The mammary region is subject to *cystic tumors*, either congenital or acquired, single or multiple, simple or compound. Their contents are variable, but, in general, they are strictly serous, and of a pale straw or amber color. Their volume ranges from that of a pea to that of an adult head; they fluctuate distinctly under pressure, are free from pain, and often grow with great rapidity.

The most remarkable instance of congenital cyst of this region that I have ever witnessed occurred in a male infant, three weeks old. The tumor was of a globular shape, and measured thirteen inches in circumference at its base; it was somewhat lobulated, soft, elastic, fluctuating, and translucent, like a hydrocele, the skin being perfectly sound, but traversed by several large veins. It was occupied by nearly a pint of yellowish, serous fluid, saline in taste, and readily coagulable by heat and acids. A cure was readily effected by the use of a seton, consisting of a few silk threads retained for forty-eight hours. The inflammation consequent upon the operation soon yielded to the use of saturnine lotions and a dose of castor oil, and the little patient made an excellent recovery. Such a tumor might be laid freely open, and mopped with tincture of iodine.

Scirrhus sometimes affects the mammary region instead of the mammary gland, its most common site being the space between the outer and lower border of the breast and axilla. I have seen several instances of this kind, in which the organ in question remained completely intact, from the commencement of the disease to its termination in death. The malady begins apparently in a lymphatic gland in this situation, from which it gradually extends in different directions until, at length, an immense tumor is developed, possessing all the characteristics of scirrhus. In a case recently under my observation, in an Irish female of seventy, both sides were implicated, although not in an equal degree. The disease was first noticed in the form of a small lump, two years previously, while on her voyage from Europe to this country. She suffered excruciating pain of a sharp, lancinating nature, and her general health was rapidly declining, with a tendency, on the part of one of the tumors, to ulceration. In none of the cases of this disease that have come under my observation was there any involvement of the axillary lymphatic glands, although it is easy to conceive that such a complication might arise during the progress of the affection.

Other morbid formations, as encephaloid, keloid, epithelioma, and chronic abscesses, are liable to occur on various parts of the chest, but, as they present nothing peculiar, they require no special notice here.

GENERAL DIAGNOSIS OF MAMMARY TUMORS.

The diagnosis of the affections of the mammary gland is not only exceedingly important but often very difficult and embarrassing. Many a breast has been sacrificed under the supposition that it was affected with carcinoma when it was merely laboring under chronic abscess or induration dependent upon neuralgia, inflammation, or lobular hypertrophy.

The diseases that are most liable to lead to error in diagnosis are, among the benign, chronic abscesses, neuralgia, hypertrophy, adenoid, cystic sarcoma, and fibrous tumors; among malignant, scirrhus, encephaloid, and sarcoma.

There is no possibility of confounding an *acute abscess* with any other disease. Its occurrence during early lactation, its rapid progress, the severity of the concomitant pain, the great swelling, the sympathetic disturbance of the system, and, lastly, the discoloration of the skin and the sense of fluctuation as the matter nears the surface, are always sufficient to distinguish its true character.

In *chronic abscess* most, if not all, of the above symptoms are wanting. The disease, usually beginning in several hard nodules, is the work of weeks, if not months; there is an increased size of the organ but no swelling, properly so called; the part has no unnatural heat; there is no discoloration of the skin, not even when the attack is of long standing; instead of pain, there is merely a sense of soreness or of weight; the general health is not materially disordered. Marked enlargement of the subcutaneous veins generally exists, especially in protracted cases, and may, unless great caution is exercised, be mistaken for that which so constantly attends confirmed encephaloid.

Neuralgia occurs early in life, generally from the eighteenth to the thirtieth year, and is usually associated with dysmenorrhœa and neuralgia in other parts of the body, especially of the chest and abdomen. The breast is not materially, if at all, enlarged, but it is exquisitely tender on pressure, and several small nodules, hard, circumscribed, and perfectly movable, are imbedded in its substance. They occasionally acquire a considerable bulk, especially if some of them coalesce. The general health is more or less impaired, and the patient is very nervous, often hysterical, and remarkably susceptible to atmospheric impressions. The nipple and axillary glands remain unchanged.

Hypertrophy, especially when not exaggerated, might be mistaken for scirrhus or encephaloid. The extraordinary bulk of the tumor, the natural appearance of the nipple, the absence of lymphatic involvement, and the lobulated character of the breast, together with its pedunculated configuration, caused by the manner in which it is dragged away from the chest, readily distinguish general hypertrophy from other affections. The subcutaneous veins are always excessively enlarged and tortuous.

The *sero-cystic* tumor, most common between the twentieth and fortieth year, is characterized by the tardiness of its progress, by a sense of fluctuation, by the absence of pain and lymphatic disease, by the natural appearance of the nipple, and by the unimpaired state of the general health. In the multilocular form of the affection the diagnosis is sometimes very obscure, especially in its earlier stages; there is less distinct fluctuation than in the unilocular cyst; and the tumor has a more solid and heavy feel.

Hydatids of the breast are very uncommon, and their diagnosis does not differ materially from that of the sero-cystic growth. More or less fluctuation necessarily exists; and, when the tumor is occupied by several bodies of this kind, a distinct fremitus, or friction sound, not unlike the creaking of new sole leather, may sometimes be elicited by rubbing the surface with the finger. When ulceration occurs, the microscope may detect the hooklets of broken-down echinococci in the discharges.

The *lacteal* tumor is recognized by its globular or ovoidal shape, its fluctuating feel, its rapid development, and its supervention upon delivery. Instead of pain, there is a sense of distention or of uneasiness, and the general health is unimpaired. The tumor often acquires a large bulk in a short time.

Fibrous and adenoid tumors are not always easily distinguishable either from each other or from other affections. In general, however, their slow development, small size, the absence of adhesions and of lymphatic involvement, the normal appearance of the nipple, the firm, elastic character of the swelling, and the integrity of the general health, will suffice to determine the diagnosis. Both of these growths are peculiar to young subjects. In the adenoid tumor, the morbid mass is sometimes remarkably lobulated, and, consequently, feels as if it consisted of numerous nodules connected by cellulo-fibrous tissue.

Of the malignant affections of the mammary gland the only ones requiring any special notice, in a general diagnostic point of view, are scirrhus, encephaloid, and sarcoma.

Melanosis usually occurs in small nodules, situated partly in the breast, and partly in the cellulo-adipose tissue, of a rounded or ovoidal figure, of a dense consistence, and of a black color, often distinguishable through the skin. The disease generally coexists with melanosis in other structures.

There are no reliable signs of *colloid*. The tumor is hard, inelastic, heavy, globular, or ovoidal, somewhat smooth upon the surface, and tardy in its growth, but capable of attaining a large bulk. The diagnosis is based mainly upon the principle of exclusion.

The differential diagnosis of scirrhus and encephaloid will be most easily understood if exhibited in tabular form.

SCIRRHUS.	ENCEPHALOID.
1. Seldom seen until after the fortieth year.	1. May occur at any time after puberty.
2. Generally begins in several small, hard, circumscribed nodules.	2. Usually begins as a single tumor or diffused mass.
3. Increases slowly, and is occasionally almost stationary.	3. Extends rapidly, and never stops in its career.
4. The breast is seldom much enlarged, except when there is an unusual quantity of fatty matter around it.	4. Great bulk is one of the characteristic features of encephaloid.
5. The tumor is hard, firm, incompressible.	5. The breast is soft and elastic, feeling, at certain points, as if it contained a fluid.
6. Retraction of the nipple is an early and prominent feature.	6. The nipple often retains its natural appearance, even late in the disease.
7. The breast, early in the disease, contracts firm and extensive adhesions to the surrounding parts.	7. Adhesions also form, but not until late, and then they are seldom very extensive.
8. The axillary lymphatic glands are always seriously involved during the progress of the disease.	8. The glands rarely suffer until after ulceration sets in and even then often very little, if at all.
9. There is no marked enlargement of the subcutaneous veins.	9. The vessels under the skin are always greatly enlarged, and sometimes very tortuous.
10. The pain is sharp, or lancinating, and begins early in the attack.	10. The pain is dull or obtuse, and seldom considerable, until ulceration begins.
11. The ulcer has an excavated appearance, with steep, sharp, everted edges, and a foul bottom.	11. The ulcer is fungous, its edges are thin and partially undermined, and the bottom is red and soft.
12. The discharge is thin and sanious, or sero-sanguinolent, and never very copious.	12. Is always very abundant, bloody, or sero-sanguinolent, like the washings of meat, and of a nauseous, almost insupportable odor.
13. There is seldom any decided bleeding, except when a vessel of considerable size is eroded.	13. Hemorrhage is frequent, and often very copious and exhausting.
14. The general health rarely suffers seriously until late.	14. Early constitutional involvement and cachectic cachexia.
15. Secondary scirrhous tubercles frequently form in the skin of the breast in the last stage of the disease.	15. No such appearances are witnessed in encephaloid.
16. The patient lasts, on an average, from eighteen months to two years and a half.	16. Death usually occurs in from nine to twelve months.

Soft, medullary, small-celled *sarcoma* is very liable to be confounded with encephaloid disease, from which, however, it may be differentiated by its occurrence in young girls and in young, robust married women, by its remarkably rapid progress, by the enormous bulk which it attains in a short time, by its uniformly soft and apparently fluctuating feel, by its freedom from lymphatic involvement, adhesion to the subjacent tissues, and, as a rule, marked enlargement of the subcutaneous veins, by its slight or only remote tendency to ulceration, and, finally, by the shorter duration

of life. *Cystic sarcoma*, most common in middle-aged females, at first grows slowly, but afterwards increases rapidly, forming a colossal, irregular, lobulated, movable tumor, the consistency of which is very unequal.

The distinction between ordinary solid tumors of the breast and the malignant formations to which this organ is liable, although not always very easy, may generally be satisfactorily established, provided the exploration is conducted with the requisite care and attention. The chief diagnostic differences are the following:—

Non-malignant mammary tumors are the most common from the twentieth to the fortieth year; they are irregular in shape, lobulated, of unequal consistence, more or less movable, tardy in their development, and seldom tending to ulceration. There is no retraction of the nipple; the skin retains its natural color, but is often sensibly attenuated, there is no enlargement of the subcutaneous veins, except in extensive hypertrophy or cystic disease; the axillary and infraclavicular glands are unaffected; there is frequently a feeling of weight and distention, but seldom any actual pain; and the general health is little, if at all, impaired. In cystic affections, there is always some degree of fluctuation, and the insertion of the exploring needle is followed by an escape of serous or sero-sanguineous fluid. Non-malignant tumors incommode by their weight and bulk, but seldom prove fatal.

In malignant growths the symptoms are completely reversed. The disease, especially in scirrhus, is seldom observed until after the fortieth year, and always advances rapidly. The tumor, of extraordinary hardness, and of uniform consistence, soon loses its mobility, and, gradually approaching the surface, ultimately breaks out into an open, intractable ulcer. The skin is discolored and indurated; the subcutaneous veins are greatly enlarged, particularly in encephaloid; the nipple is retracted; the axillary lymphatic glands are more or less implicated; the pain, at first slight and occasional, soon becomes constant, and is of a sharp, lancinating character; the health suffers severely; and the countenance exhibits the peculiar carcinomatous cachexia. The disease is invariably fatal, the period at which death occurs varying from twelve months to two years and a half. Rapidity of growth and inordinate bulk should always excite suspicion of malignancy, especially if associated with great enlargement of the subcutaneous veins and marked failure of health. A bloody, sanious, or ichorous discharge from the nipple is generally a sign of ill omen. When ulceration exists, a particle of the diseased structure may be clipped off, and examined microscopically with a view to the detection of carcinomatous structure.

EXCISION OF THE BREAST.

A certain amount of preliminary treatment is always necessary in excision of this organ. In most cases, there is marked disorder of the secretions, which should, therefore, be carefully corrected; the diet should be properly regulated; and the bowels should occasionally be opened by a mild laxative, as blue mass and rhubarb, or the compound cathartic pill.

The operation itself is generally a very easy and simple affair. It is only when the organ is much enlarged by disease, or when it is very vascular, that it is likely to prove annoying and embarrassing, especially if there is not a sufficiency of assistants. During its performance, the patient may either sit up or lie down; the latter posture I always prefer, as it gives us better control over the parts, at the same time that chloroform may be administered with greater safety.

In most cases, it will be necessary to remove a portion of integument, particularly if the breast is at all large, or if there is any cutaneous involvement, either actual or impending. Hence the incisions, as shown in fig. 712, should usually be elliptical; and it will be well, if possible, always to make them in the direction of the fibres of the great pectoral muscle, as this will tend to facilitate both the liberation of the organ and drainage after the operation. The surgeon, however, is not always able to control this matter, owing to the peculiar condition of the parts, and he will, therefore, occasionally be obliged to make his incisions very oblique, or, indeed, almost perpendicular. In all cases an attempt should be made to save enough integument for the easy closure of the wound; for I deem it a matter of great moment that as much of it as possible should be healed by the first intention, convinced that such a result will be much less likely to be followed by speedy relapse than when the parts are permitted to gap.

Fig. 712.



The integument being properly stretched, and the arm held off nearly at a right angle from the body, the knife is thrust through the skin and cellulo-adipose tissue, and carried around the diseased mass in such a manner as to include every particle of it, the lower incision being always made first. The dissection is then performed in the direction of the fibres of the pectoral muscle, which should be thoroughly exposed by the removal of its aponeurotic envelop. If any arteries of considerable size spring, they should immediately be compressed by the finger of an assistant, and carefully tied as soon as the operation is over, together with any of the smaller branches that might afterwards become a source of hemorrhage. When the tumor is inordinately vascular, it may be prudent to ligate each vessel as soon as it is divided, but this is generally an awkward and unnecessary proceeding. Before the parts are approximated, the wounded structures are examined with the greatest care, in order that not the slightest particle of the morbid substance may be left. Indeed, the very atmosphere of the disease should be removed. The fact that the tissues around the tumor, although apparently perfectly healthy, are often infiltrated with carcinomatous cells, has been demonstrated by numerous observers, and is too important to be overlooked in an operation of this kind.

Copious hemorrhage will be most likely to attend this operation when it is performed on account of encephaloid, sarcomatous, or of large scirrhus tumors which have formed strong and extensive attachments to the surrounding and subjacent structures; even then, however, it may always be readily controlled by the pressure of assistants until the morbid mass is completely liberated.

The adjoining sketch, fig. 713, affords a correct illustration of the position of the patient in this operation, of the lines of the incisions, and of the mode of separating the morbid mass.



Excision of the Breast.

If any of the lymphatic glands in the axilla are involved, they should be dealt with in the same manner as the breast itself, either by an extension of the outer angle of the incision, or by an incision immediately over the affected structures, which are then generally readily enucleated with the finger or the handle of the scalpel. This is often the most difficult and dangerous part of the operation, especially when these

bodies are much enlarged, very numerous, thoroughly matted together, or closely hugged by the axillary artery, nerves, and vein. If, in such an event, the point of the knife be used, very serious mischief will be likely to be done.

The number of lymphatic glands in the axilla is much greater than is generally imagined. In one instance, in a case of scirrhus of the breast in a woman, forty-five years old, I counted as many as forty-eight, from the volume of a small pea to that of a partridge egg. They were very hard, dense, almost cartilaginous, and very easily enucleated.

My rule of practice, after excision of the mammary gland, formerly was to keep the wound open for four or five hours after the operation, lest secondary hemorrhage should arise, and thus necessitate the removal of the dressing, the surface being covered, in the interval, with a light, soft cloth, frequently wet with cold water. Of late years, however, I have usually closed it as soon as all bleeding has ceased, and this, as a general rule, will be found to be the preferable method. In dressing the wound, care should be taken to use only a few stitches, and to press the flaps well down with long, narrow strips of adhesive plaster, aided by a compress and bandage, carried around the upper part of the chest. The arm should either be supported in a sling or secured to the side of the chest; the treatment should be gently antiphlogistic; and the dressings should not, as a general rule, be disturbed until the end of the third day, except in very hot weather, when it may be necessary to remove

them sooner. When there is a want of integument, or injurious tension, it will be well, in the former case, to borrow a sufficiency from the neighboring parts, and, in the latter, to ease the flaps by suitable incisions, practised a short distance from the edge of the wound.

Any tendency to bagging during the after-treatment should at once be counteracted by a free incision at the most dependent portion of the flap. Experience has shown that retained secretions soon become a source of irritation, provoking fever, erysipelas, pyemia, and phlegmonous abscess. I saw, not long ago, a patient perish from this cause within four days after the operation. An enormous quantity of thin, foul, offensive matter had accumulated under the flap, causing rapidly destructive pyemia.

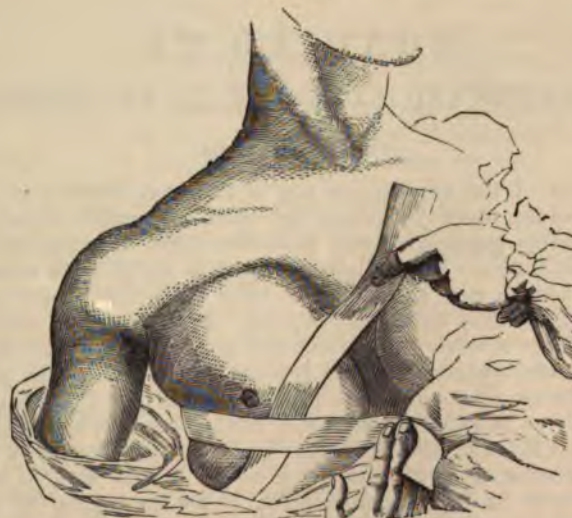
When the wound is healed, the parts should be well protected with a thin satin quilt, or a tanned rabbit skin, especially during cold weather; all pressure from the clothes should be prevented; and the corresponding arm should be constantly carried in a sling, to relieve the chest and shoulder of the weight of the limb.

Very few women perish from the effects of this operation in private practice. Among hospital subjects, however, a fatal termination is by no means uncommon. Of 235 cases of excision of carcinomatous and other diseased breasts, analyzed by Paget, 23, or ten per cent., died. Velpeau lost 32 in 167, or 1 in 5 $\frac{1}{4}$. The chief danger is from erysipelas, which occasionally occurs despite the greatest care both of the patient and of the surgeon. I have lost only two patients from this cause out of nearly two hundred from whom I have excised the breast. Both were uncommonly fat, and both were impressed with the conviction that they would not recover from the effects of the operation. Death may also arise from pleurisy, pneumonia, pyemia, and diffuse suppuration. Fat, portly women, with large breasts, do not bear the operation as well as the more common class of subjects; very nervous ones also sometimes run great risk. In general, however, the case proceeds favorably; much of the wound often unites by first intention; and the cicatrization is usually completed in from three to four weeks.

BANDAGES FOR THE BREAST.

The breast, like other organs, demands, when diseased, proper rest and support. The duty of the surgeon is very imperfectly discharged if he do not attend to these

Fig. 714.



Strapping of the Breast.

important points. For ordinary purposes the organ may be easily sustained with a light silk handkerchief, thrown around the opposite shoulder, and so arranged as to make equable pressure. When greater nicety is required, a special apparatus may be used, consisting of a silk or gum-elastic web, adapted to the shape and size of the

gland, and secured to the trunk by shoulder-straps and a body-piece, the mode of construction and application being similar to those of the suspensory bandage for the scrotum. A beautiful contrivance of this kind is made in this city at the Nurses' Home.

Fig. 715.



Sling for the Breast.

Sometimes the object may be advantageously attained by means of two broad adhesive strips, carried loosely across the breast, as in fig. 714; or by splitting a piece of old linen into two tails, one of which is fastened around the body, while the other is passed over the shoulder, thus supporting the organ in the form of a sling, as exhibited in fig. 715.

CHAPTER XX.

DISEASES AND INJURIES OF THE EXTREMITIES.

GUNSHOT WOUNDS.

GUNSHOT wounds of the extremities are of frequent occurrence in time of war, and commonly require much judgment for their successful management, as they involve every possible grade of injury from the most insignificant scratch to the most appalling mutilation. The collapse is often so great as to cause death, either immediately or within a very short period after their receipt, the system, perhaps, never making the slightest effort at reaction. In the inferior extremity the shock and danger to life are always proportionately greater than in the superior, gunshot wounds and fractures sharing, in this respect, the same fate as common wounds and fractures. These effects increase in a marked degree as the injury approaches the trunk, precisely as in amputations, those of the foot and leg being attended with much less risk than those of the thigh and hip. During the war in the Crimea, the ratio of mortality after amputations for gunshot lesions was, in round terms, 14 per cent. for the foot, 22 for the ankle-joint, 30 for the leg, 50 for the lower third of the thigh, 55 for the middle third of the thigh, and 86 for the upper third of the thigh, all amputations of the hip-joint having proved fatal.

Gunshot injuries of the extremities may, very properly, be arranged under the following heads, according to the nature of the parts involved: 1st, Wounds simply or mainly of the muscles; 2dly, wounds of the vessels; 3dly, wounds of the nerves; 4thly, wounds of the joints; and, 5thly, wounds of the bones.

1. *Wounds of the Muscles.*—Gunshot wounds of the muscles, or simple flesh wounds, are not, generally, of themselves dangerous, even when of large extent, but they may readily become so when they occur in a person of intemperate habits or impaired constitution, or even when the health was excellent at the time of the injury, from exposure, fatigue, or improper management. Erysipelas will then be very liable to arise, followed by high excitement, and by the formation of large abscesses, the pus often burrowing extensively among the surrounding structures; ordinarily, however, such injuries will, for the most part, do well, the patient making a rapid recovery with a good use of the limb. Of upwards of three hundred cases of flesh wounds of the upper and lower extremities which I saw after the battle of Bull Run, very few died. Indeed, most of the men were able in a short time to return to duty. Shell wounds of the muscles are usually more dangerous than wounds made with rifle balls. In the hospital at Georgetown, I saw a man, aged thirty-eight, who died at the end of seven days from a frightful wound on the outside of the thigh, at least ten inches in length by four in width, caused by the bursting of his musket. As an offset against this case, I may mention one which occurred during the Mexican war, in a young private of the 2d Kentucky Regiment, who made an excellent recovery, although it would be difficult to conceive of a more terrible flesh wound. Here the muscles of the right hip and of the outer and back part of the thigh, as low down as the popliteal space, were almost entirely torn away by a shell, which at the same time denuded the head of the femur and the femoral artery, the pulsations of which were distinctly perceptible at the inner side of the limb. Notwithstanding this horrible mutilation, rapid recovery took place, and when I saw the man, three months after the accident, the parts were nearly cicatrized, without much impairment of function.

Flesh wounds of the shoulder and back, inflicted by gunshot, are not, in general, dangerous. Of twenty-six men belonging to one of the Kentucky regiments, who were injured in this situation at the battle of Buena Vista, in 1847, not one died. The ball in nearly all had penetrated the deltoid muscle, and, passing upwards over the shoulder, lodged in the neck and back, from which it was afterwards extracted.

The treatment of such injuries resolves itself into the removal of foreign matter, and the use of water-dressing, with rest and elevation of the limb, and attention to the diet, bowels, and secretions. The eschars, if there be any, will usually separate in five or six days, followed by healthy granulations, and there will seldom be any necessity for dilating the parts, unless there should be excessive tension, as when they are invaded by erysipelas, or when matter forms and threatens to burrow among the neighboring structures.

2. *Wounds of the Bloodvessels.*—The large vessels suffer much less frequently in gunshot wounds than might at first sight be supposed, their great resiliency enabling them to glide out of the way of the flying missile. An instance has been recorded by Mr. Guthrie in which a ball passed between the femoral artery and vein without dividing either. The fact is, this class of injuries is comparatively exempt from copious hemorrhage. It is only when a large artery or vein is perforated that the patient, unless promptly succored, will be likely to bleed to death. To this, however, there is occasionally an exception. Thus, Larrey mentions the case of a soldier who, struck on the inferior third of the thigh by a ball, experienced one severe hemorrhage, which was never repeated. The limb soon became cold, the popliteal artery ceased to beat, and the extremities of the divided vessel could be felt when the finger was pressed into the wound. Perfect recovery ensued. At the siege of Antwerp a case occurred in which both femorals were severed by a shell, and yet there was hardly any bleeding, although there was extensive destruction of the soft parts. Sometimes a vessel, instead of being opened, is merely contused and slightly lacerated, the ball grazing its coats, which, inflaming, may ultimately give way, and thus lead to troublesome, if not destructive, hemorrhage. Such an event, which it is not always in our power to foresee, but which may reasonably be anticipated when the missile has passed in the direction of a large artery without having occasioned any serious bleeding, is most liable to occur from the sixth to the eighth day, and is always greatly to be deplored, inasmuch as, arising at a period when it is not expected, it may prove fatal before the necessary assistance can be rendered. It is, therefore, highly proper, in all such cases, to keep the limb for several days constantly encircled with a tourniquet, the use of which should be fully explained

to the patient and his attendants, so that there may be no serious loss of blood in the absence of the surgeon.

A vessel, grazed by a ball, does not always, unless devitalized, give way under the effects of its injuries; on the contrary, the wounded part is often successfully repaired, or the canal at the site of the mischief is permanently obliterated by the formation of a clot.

The causes of secondary hemorrhage in gunshot wounds of the extremities are: 1st, injury inflicted upon the vessels by the missile, or by a sharp spiculum of bone; 2dly, the premature detachment of the clot, in consequence of sudden and violent bodily exertion, attended with great increase in the force and rapidity of the heart's action; and, 3dly, a want of plastic power in the blood, dependent upon the hemorrhagic diathesis, or the effects of an inadequate supply of vegetable food. The period at which the bleeding thus occasioned sets in varies, on an average, from five to twenty days.

The treatment of a wounded artery consists in exposing it at the seat of the injury, and applying two ligatures, one above and the other below the opening. This should be done as speedily as possible after the accident, before there is any considerable inflammation or swelling. Tying the vessel at its cardiac side alone will not suffice; unless it is secured also at its distal extremity, hemorrhage from the recurrent circulation will be inevitable. The operation should be performed even when all bleeding has ceased, especially if the patient is obliged to be transported to any distance. Venous hemorrhage may generally be effectually arrested by compression; the ligature should be employed only in the event of its failure.

When the wound involves the principal artery and vein of a limb, amputation will generally be required, in anticipation of the mortification which is so liable to occur in such an event from the interruption of the circulation. The operation, in fact, is sometimes demanded even when only one of these vessels is severely injured.

3. *Wounds of the Nerves.*—Unless the nerve is very large, a gunshot wound of it will not be likely to eventuate in any trouble, beyond a slight temporary paralysis or loss of sensation. Under opposite circumstances, however, the mischief may be very great; for then there may be, in addition to these effects, danger of mortification from the interruption of the nervous fluid, just as a limb may perish from the want of blood when its main artery has been divided. The mortification, in such a case, may be direct—that is, it may be caused by the mere suspension of the nervous power of the parts—or indirect, through the medium of inflammation; the latter being the more common. Occasionally a gunshot wound of the nerves is followed by severe neuralgia, lasting, perhaps, for years, if not during the remainder of life.

In the English army in the Crimea, only 23 cases of gunshot wounds of the brachial plexus and larger nerves, as the median, ulnar, and sciatic, are reported to have occurred; of which 9, or 41 per cent. of the whole, proved fatal. The cause of death in 5 of the cases was tetanus. Partial division of the nerves was sometimes followed, especially in the upper extremity, by total loss of sensation and power, which, although occasionally recovered from, often ended in atrophy, or atrophy and contraction of the muscles, with permanent disability of the limb.

Valuable light was thrown upon many of the more remote effects of gunshot injuries of the nerves by the observations of Dr. S. Weir Mitchell and his colleagues, Dr. Morehouse and Dr. Keen, during the late war, at the Army Hospital for Diseases of the Nerves, in this city. Among the more remarkable of these effects, some of which had previously escaped attention, are the changes which the skin and its appendages undergo from the impairment of their nutritive functions. The skin is shrunken, glossy, discolored, partially deprived of cuticle, and so exquisitely sensitive as to render it intolerable to the slightest touch. These phenomena are particularly conspicuous in the hands and fingers; they also occur, although less distinctly, in the feet and toes. The skin looks as if it were tightly stretched; little spots, or patches, of a reddish, purple, or bluish color, exist upon its surface; and it is not uncommon to meet with minute cracks, fissures, and vesicles, similar to those observed in eczema. Conjoined with these affections are generally loss of hair and incurvation of the nails, the latter being often so remarkable as to be almost pathognomonic of this class of injuries. Ulcerations, of an obstinate, painful character, often exist at the edges of the nails, and add greatly to the patient's suffering.

The joints are often swollen, stiff, tender, and painful; the tissues around are

indurated, from interstitial deposits; and troublesome, if not permanent, ankylosis frequently ensues.

Among other phenomena noticed by Dr. Mitchell is a remarkable burning pain in the hands and feet, especially on the palmar surface of the former, and the dorsum of the latter; coming on at a variable period after the receipt of the injury, lasting for a longer or shorter time, and generally referred to the skin or superficial structures. It varies in degree from the most trivial burning to exquisite torture. It is aggravated by exercise, by dependency of the part, and by exposure to heat and dry air, but relieved by cold and moisture.

When these affections exist in a high degree, they are always attended with marked disorder of the constitution, loss of sleep and appetite, derangement of the secretions, irritable temper, and excessive impressibility to atmospheric vicissitudes. They may be caused apparently by the most simple hardly less than by the most severe injuries. In many cases they follow upon the most trivial contusions.

It is not always easy to decide upon the proper course of treatment in gunshot wounds of the nerves. In the milder cases, the same plan should be adopted as in common flesh wounds. If the nerve is completely, but irregularly, divided, or much contused and lacerated, the safest procedure will be to cut off its ends smoothly, and to tack them nicely together with the silver-wire suture, hoping for ultimate reunion through the agency of plastic matter; but if the intervening space is considerable, such treatment would, of course, be improper. If the main nerve of a limb is completely severed, amputation may be required, especially when the injury is complicated with lesion of an important vessel; but, even then, the surgeon should greatly hesitate before he undertakes so terrible an operation.

For the more remote effects of these injuries much may be done by attention to the general health, the use of tonics and alterants, change of air, and the correction of the secretions. The burning pain and hyperæsthesia of the skin are most effectually relieved by thorough vesication, first with liquid ammonia, and afterwards with cantharides, along with hypodermic injections of morphia, and cold water-dressing. Dr. Mitchell has found all other means, both local and constitutional, perfectly inert and unreliable. In some of his more obstinate cases he was obliged to employ as many as six, eight, or even ten blisters before he was able to make any very decided impression upon the disease.

4. *Wounds of the Joints.*—The gravity of gunshot wounds of the joints has been recognized by all practitioners, military and civil, since the invention of firearms. The principal circumstances influencing the prognosis are the size and complexity of the articulation, the extent of the injury, and the state of the system and previous health of the patient. A gunshot wound of a ginglymoid joint is, in general, more dangerous than one of a ball-and-socket joint, and a gunshot wound of the hip, knee, and ankle, than one of the shoulder, elbow, and wrist. The structures around the articulation often suffer severely, thus adding greatly to the risk of limb and life. Of 65 cases of gunshot wounds of different joints, related by Alcock, 33 recovered, but of these 21 lost each a limb. Of the 32 that died, no operation was performed upon 18.

Gunshot wounds of the smaller joints often do well, although they always require long and careful treatment. Lesions of this kind involving the shoulder are frequently amenable to ordinary means. If the ball lodge in the head of the humerus, as in fig. 716, it should be extracted without delay, its retention being sure to excite violent inflammation in the soft parts, and caries or necrosis in the bone, ultimately necessitating amputation, if not causing death. If the bone is at all shattered, the proper operation will be resection.

Gunshot injuries of the elbow generally do well under resection; it is only when there is extensive lesion of the soft parts, along with great comminution of the bones, that amputation will be likely to be required. Similar remarks are applicable to gunshot injuries of the wrist and carpal joints.

Gunshot wounds of the hip, knee, and ankle joints are always to be considered as serious accidents, very liable to be followed by loss of limb and life. The danger is a hundred-fold increased when there is severe involvement of the articular extremities of the bones, as in fig. 717. Gunshot wounds of the knee are the most dangerous of all. Of upwards of forty cases of this kind in the French



Fig. 716.

Ball imbedded in the Head of the Humerus.

hospitals in the Crimea, in which an attempt was made to save the limb, all, except one, proved fatal. Of nine cases which occurred in India, not one was saved. Guthrie

never saw a gunshot wound of the knee-joint attended with severe injury of the bones, recover without removal of the limb; the experience of Larrey was of the same nature; and Esmarch declares, as the result of his observation in the Schleswig-Holstein campaigns, that all lesions of this description demand immediate amputation of the thigh.

Frightful injury is sometimes inflicted upon a joint indirectly, as when a ball, passing through the extremity of a long bone, causes a fissure which extends through the synovial membrane, as in fig. 718. Occasionally the missile traverses a joint, channeling a groove into the articular cartilage, but not inflicting any serious lesion upon the integument. Such accidents, although, perhaps, apparently insignificant, are often followed by the most violent

Fig. 717.



Bones of the Knee Fractured
by an Impacted Round Ball.

Fig. 718.



Perforation of the Femur with
Fissure into the Joint.

inflammation, imperilling both limb and life. Patients sometimes perish from secondary involvement of a joint, its structures taking on fatal action in consequence of a severe wound in its immediate vicinity. Lastly, an articulation may suffer terribly from gunshot injury without any external wound, as when it is struck by a partially spent ball or shell. Under such circumstances, indeed, as has been shown by Ledran, Legouest, and others, a joint may be completely dislocated, and yet the integument remain intact.

When, in the more violent forms of these articular injuries, an attempt is made to save the limb, the patient often perishes within the first three or four days, from the conjoined effects of shock, hemorrhage, and traumatic fever. If he survive for any length of time, large abscesses are liable to form in and around the joint, the matter burrowing extensively among the muscles, and causing detachment of the periosteum, with caries and necrosis of the bones.

From all, then, that precedes, it may be assumed, as a general proposition, that, in the milder cases of these injuries, especially as they occur in the more insignificant joints, the ordinary precepts of conservative surgery should be enforced; whereas, under opposite circumstances, it will usually be necessary either to resect the articular extremities of the bones, or to remove the limb at a suitable distance above the seat of the injury. Excision is adapted chiefly to gunshot wounds of the joints of the superior extremity, while amputation is more frequently required in those of the inferior extremity. All large wounds of the knee-joint, or even comparatively small ones, if they involve the epiphysis of the femur or tibia, imperatively demand the latter operation; and few cases of gunshot injuries of the ankle will be likely to arise on the field of battle in which such a procedure would not be preferable to excision.

5. Wounds of Bones.—The effects of balls upon the osseous tissues are subject to great diversity. In the first place, the injury may be very superficial, involving merely the periosteum or this membrane and a little of the compact substance of the bone; or, secondly, the missile may simply strike the bone, causing more or less severe concussion of its substance without penetration, but yet inflicting a sufficient amount of mischief to induce violent inflammation, terminating in abscess, caries, or even necrosis; or, thirdly, the ball, as it courses along, may plough a groove into its surface, also liable to be followed by bad effects; or, fourthly, the ball may produce a partial fracture, without complete detachment of the fragment, as represented in fig. 719; or, fifthly, the vulnerating body may enter the bone, breaking and comminuting it,

as in fig. 720, each fragment, as it is driven about among the soft parts, becoming thus an additional source of injury. The old round ball often glanced when it came in contact with a bone, but the Minié ball almost invariably perforates it, grinding it at a fearful rate, and so producing the very worst form of compound fracture.

The number of fragments is extremely variable; thus, there may, on the one hand, be only two, three, or four, or, on the other, as many as a dozen or twenty, or even thirty. Their size, too, is very indefinite. Some of the fragments may be entirely detached, while others may retain their connection with the main body of the bone, either by osseous tissue or through the periosteum.

A long bone, instead of being broken, may be simply perforated. Hennen relates two cases in which the shaft of the femur was thus pierced, and three cases are referred to by Esmarch, in which a similar accident befell the upper third of the tibia. The lesion has also been observed in the humerus, radius, and ulna.

A bone is sometimes terribly shattered by a large stone, struck and set in motion by a round shot, or a fragment of shell. Occasionally, again, a severe fracture is produced by a ball in ricochet without any apparent injury whatever of the integument, as in a case which I saw at Washington, in a sergeant of Rickett's Battery, who was struck in this way on the arm by a twelve pound shot, which broke the humerus at three different points, but did not even bruise the skin.

In the treatment of this class of injuries, the first object, if the limb can be saved, is to stanch hemorrhage, and to extract any loose splinters of bone that may be present. The wound should be thoroughly examined with the finger, the patient being, of course, under chloroform, and no efforts should be spared to place the parts in the best possible condition for early reunion. A superficial exploration is worse than useless. The work must be done thoroughly and promptly, otherwise the patient will be subjected to immense pain and suffering, if not to ultimate loss of limb and life. I am satisfied from what I have seen of such cases that these injunctions are frequently most shamefully neglected.

In the milder forms of the injury, the treatment must be conducted according to the ordinary rules of practice; by rest, elevation, and medicated water-dressing, conjoined, if necessary, with leeches and scarification, especially if erysipelas should arise. If the bone is severely broken and comminuted, resection, or amputation, will probably be required, and should be performed at once, as soon as reaction is sufficiently established. Gunshot fractures of the femur are particularly dangerous, especially when inflicted with the Minié ball, and frequently demand amputation on account of the frightful shattering of the bone, causing not only great shock, but, if the patient survives, rapid and extensive swelling of the soft parts, followed by copious infiltration of pus. In the Crimea, a bad compound fracture of the thigh was considered as synonymous with death; and the surgeons of the Black Sea Fleet never attempted to save a limb after such an injury, except at the risk of the patient's life. Stromeyer, in commenting upon the subject, declares that gunshot injuries of the shaft of the femur are among the most dangerous lesions of the bones, and he adds that they are particularly liable to end unfavorably when they are produced by a piece of exploded bomb or a grazing cannon ball, without division of the soft parts.

Fig. 719.



Partial Longitudinal Fracture
of the Femur by an Impacted
Conoidal Ball.

Fig. 720.



Comminution of the
Humerus by a Conoidal
Ball.

Numerous instances, one of which is represented in fig. 721, occurred, during the late war, of recovery from gunshot fractures of the middle and upper third of the

Fig. 721.



Consolidated Gunshot Fracture, with shortening of four inches.

thigh, with a very useful, although generally a much shortened and deformed, limb. Not less than half a dozen of such cases came under my immediate observation at the George Street Military Hospital of this city; and hundreds of similar instances can attest the skill and attention of our army surgeons elsewhere. The most simple treatment alone is usually admissible in this class of injuries. Hardly any apparatus is required, beyond a few short splints at the seat of fracture, and two long, broad adhesive strips to secure the limb to the foot of the bedstead. Sometimes a long bracketed splint may advantageously be applied. Occasionally the limb may be suspended in a sling, or supported with a Smith's anterior splint; but the straight position will generally be found to be most comfortable to the patient, and best adapted to a good union. The requisite degree of counter-extension may generally be readily made by simply elevating the foot of the bedstead. The wound must, in bad cases, be dressed at least twice a day, dead bone removed as soon as it is detached, and bagging of matter prevented by suitable counter-openings and the use of the bandage.

A ball impacted in the superior extremity of the femur is very liable to be followed by abscess of the joint and caries, if not also necrosis, of the bone, necessitating amputation. In the medical museum at Nelsey, England, is a preparation in which an old matchlock ball was found firmly imbedded in the head of the femur three weeks after death, caused by tetanus. The missile had entered opposite the great trochanter, and passed through the brim of the acetabulum. The capsular ligament was filled with pus and splinters of bone. In the case of an officer, narrated by Larrey, a ball remained in the neck of the femur for twenty years, the man finally dying of disease of the chest. Gunshot fracture of the superior extremity of the bone, extending into the articulation, almost inevitably gives rise to violent inflammation and profuse suppuration, followed, if left to nature, by hectic irritation, pyemia, erysipelas, and osteophlebitis.

A remarkable instance of recovery of gunshot fracture of the thigh occasionally occurs when the condition of the limb is apparently in the most desperate condition. Of this description was the case of Lieut. Adams, detailed in the chapter on gunshot wounds. The injury could hardly have been more frightful, and yet he got well with a very useful limb. An example like this should certainly serve to admonish the military surgeon not to sacrifice indiscriminately every limb, even when the injury is apparently of the most hopeless nature; unfortunately, however, he cannot always, on the field of battle, carry out the dictates of his judgment; everything around him is unpropitious, and he is, therefore, often compelled to use the knife in cases which, under more auspicious circumstances, as it respects locality, air, nursing, and after-treatment, he might possibly have saved.

Gunshot fractures of the *patella*, unless attended with great comminution of this bone, and penetration of the knee-joint, do not necessarily require amputation. The cases observed by Hennen, Stromeyer, Tripler, and other military surgeons, show that such accidents are often followed by excellent recoveries. Extensive laceration, on the contrary, of the ligament of the patella, with wound of the synovial membrane, will usually result badly if an attempt be made to save the limb.

Gunshot fractures of both bones of the leg are also, generally speaking, bad accidents; great swelling, followed by diffuse abscess, usually rapidly sets in, and, unless the patient is peculiarly fortunate, he will be very apt to sink under the effects of erysipelas, pyemia, osteomyelitis, or hectic irritation, not to say anything of the danger of mortification, which is often very great, especially when the bones are comminuted, at the same time that severe injury has been sustained by the soft parts. Gunshot fracture of the fibula alone is usually much less serious than similar injury of the tibia.

Gunshot fractures of the tarsal bones are generally grave accidents, liable, if an attempt be made to save the limb, to lead to very serious consequences, especially

when the injury has been inflicted by a Minié ball or a piece of shell. I have seen several instances of the kind caused by the common round ball, which were promptly followed by tetanus and death and such occurrences are by no means infrequent in military practice.

Gunshot fractures of the arm, forearm, and hand are, compared with similar lesions of the inferior extremity, generally of a much less grave character, requiring, on the one hand, much less frequently amputation, and admitting, on the other, much oftener of resection. A great deal, of course, will depend, in every case, upon the extent of the comminution and the amount of injury sustained by the more important soft structures.

A very terrible form of contusion is sometimes inflicted upon the upper extremity of artillerymen by the premature explosion of the gun in the act of loading; causing excessive commotion of the entire limb, horrible laceration of the soft parts, and most extensive infiltration of blood, accompanied, in many cases, by comminuted fracture, and penetration of the wrist and elbow-joints. The constitutional shock is usually great. If an attempt be made to save the parts, diffuse suppuration, and more or less gangrene, will be sure to follow, bringing life into imminent jeopardy. The proper remedy is amputation, performed promptly at a considerable distance above the apparent seat of the injury, otherwise mortification will be apt to seize upon the stump.

Gunshot fractures of the extremities are often attended with frightful hemorrhage, in consequence of the injury sustained by the soft parts from the loose splinters which are often driven about in every direction. The blood may proceed altogether from the smaller vessels, and the amount effused may be such as to cause the most extensive infiltration of the areolar tissue, both beneath the skin and among the muscles; or a large artery or vein may be opened, producing great distention of nearly the entire limb, especially if there is accidental closure of the wound. The parts will be found, immediately after the occurrence, to be cold and numb, and of a remarkably pale appearance, soon succeeded by a mottled, purplish hue, and this, in turn, if the patient survives, by a greenish or brownish color.

When an attempt is made to preserve the limb, the first duty is to extract all the loose pieces of bone, and the second to place the ends of the fragments in accurate apposition, retention being afterwards effected in the usual manner. Special attention must be paid to drainage and cleanliness. Splinters, unless very small and sharp, that still retain a decided connection with the parts, whether by osseous matter or periosteum, should not be molested, as they will in all probability soon unite, and thus afford important aid in the process of repair. If they are thrown off during the suppurating stage, it will be sufficiently easy to extract them through the sinuses in the soft structures. At all events, it will be well, in every case, not to be over-officious; for by too much cutting and pulling an enormous amount of harm may be done, not only by causing improper waste of blood, but by interrupting nutrition, and permitting too free access of air.

When, in addition to serious injury of the bones, there is extensive infiltration of blood, the case may generally be regarded as a bad one, likely, if an attempt be made to save the limb, to eventuate in mortification. In the slighter forms of the accident, the blood will usually rapidly disappear under the use of the roller and of spirituous lotions.

In the treatment of gunshot wounds of the carpus and metacarpus, the greatest care should be taken to pick away every particle of loose bone, and to place such pieces as are retained in the most suitable position for accurate and speedy reunion. Unless this be done, the hand will become enormously swollen, numerous abscesses will form, and the soft parts will be so completely matted together by lymph and new osseous matter as to render them permanently stiff and useless. Similar measures should be adopted in the treatment of gunshot injuries of the tarsus and metatarsus.

If amputation be advisable, it must not be performed too near the seat of the injury, as the effects of the mischief often extend much farther than the eye can discern, especially when it has been inflicted by a shell or heavy ball. The proper time for performing the operation is the moment sufficient reaction has taken place.

AFFECTIONS OF THE NAILS.

When a nail is torn away along with its root, perfect regeneration is, of course, impracticable; a slight attempt at reproduction may occur, but nothing more. When the matrix remains, a new nail, generally as smooth and perfect as the original one, will in due time be formed. The period required for the development of the nail of the thumb, in this condition, is, according to my observation, about four months and a half, a few weeks less being required for the nails of the fingers.

Wounds of the nails, whether transverse, oblique, or longitudinal, possess the peculiarity of being insusceptible of repair. The transverse and oblique always disappear with the natural growth and extension of the nail, and the same is true of the vertical, except when it extends through the entire matrix of the nail, when it invariably remains as a rough, irregular fissure, causing more or less permanent inconvenience.

Contused and lacerated wounds of the nails are always excessively painful, and are often followed by severe inflammation and even considerable suppuration. They should be treated in the usual antiphlogistic manner, with special attention to rest and elevation of the part. If matter form, an early opening should be made for its evacuation. The blood which is so often effused under the nail in external injury generally disappears spontaneously; should it remain, and cause painful pressure, an operation may be necessary.

Splinters of wood, pieces of glass, and other foreign bodies are liable to be forced under the nails, causing violent pain and severe nervous symptoms, followed, if not speedily removed, by a bad form of inflammation. Extraction may generally be easily accomplished with the common dissecting forceps, but I have sometimes found it necessary to make quite an extensive incision before dislodgment could be effected.

The nails are liable to be seriously effected by different mechanical occupations, as dying and tanning, becoming short, thickened, fissured, tender, and painful. In herpetic diseases they are often very short, scaly, and of a thick, rounded, button-like form. In Polish plait, the nails both of the fingers and of the toes sometimes acquire an extraordinary bulk, and a yellowish, livid, or black complexion. In strumous persons they are occasionally deeply grooved, enlarged, and of a firm, horny consistence; and the changes which they now and then undergo in tertiary syphilis are well known to every one. In paralysis of the limbs their growth is often temporarily arrested, especially if dependent on softening of the brain.

Some of these affections admit of relief, while others are either partially or wholly incurable. In all cases, the first object should be to get rid of the exciting cause, when the morbid action will often disappear under the most simple applications. When the disease, whatever it may be, is at all obstinate, or of long standing, the local treatment must be conjoined with internal remedies, of which the most valuable are iodide of potassium and mercury, especially when there is a strumous or syphilitic taint. The best topical means are lotions of copper, tannic acid, chloride of zinc, and bichloride of mercury. Zinc ointment is also of great value, and in some cases signal benefit accrues from the dilute ointment of nitrate of mercury.

To keep the nails in a sound condition it is impossible to bestow too much attention upon them in the way of cleanliness and paring. It is the neglect of these precautions that entails so much disease upon them among the lower classes of people.

ONYXITIS.

Onyxitis usually begins in a small circumscribed swelling of the ungual matrix, attended with more or less pain and discoloration of the skin. A narrow ulcer or cleft soon appears at the root of the nail, and gives vent to a thin, ichorous fluid. The sore gradually extends, until it finally involves the whole of the ungual matrix, or even the entire nail. The surface has a foul, dirty aspect; the margin is thin and sharp; the discharge is irritating and offensive. The skin around the ulcer is indurated, tender, and livid; the nail is yellowish, brownish, or black, dry, and disfigured; and the affected member, often twice or thrice the normal size, has a peculiar bulbous appearance. In some instances the nail becomes loose, and ultimately drops off. The pain, which is generally slight, is occasionally so excessive as to deprive the patient of appetite and sleep for days and nights together. The disease is slow in its progress, and may continue for many months before it is arrested. Although

not strictly of a malignant nature, its tendency is to destroy the affected nail, and to produce serious changes in the surrounding structures.

Onyxitis is most common in the great toe, thumb, and index finger. It commonly occurs before the twelfth year, chiefly in scrofulous, ill-fed subjects, or in children whose system has been deteriorated by syphilis. The fact is there is reason to believe that it is generally, if not invariably, merely one of the more remote hereditary effects of this complaint. External injury, as a bruise or puncture, may provoke the disease, but in most instances it arises without any assignable cause. The health often suffers in onyxitis,

Fig. 722.



Onyxitis of the Big Toe.

Fig. 723.



Onyxitis of the Index Finger.

and the secretions are almost always considerably disordered. The annexed drawing, fig. 722, from a clinical case, conveys an excellent idea of this affection as it occurs in the great toe, and fig. 723, from Druitt, as it shows itself in the finger.

The *treatment* of onyxitis is sufficiently well established. After the bowels have been cleared out, and the secretions reëstablished, the system should at once be brought under the influence of mercury, carried to the extent of slight ptyalism. The best preparations are calomel and blue pill, the latter of which is usually preferable, because it is more mild and gradual in its operation. It may be administered two or three times a day, in the proportion of three to five grains at a dose, with a small quantity of opium to prevent griping and purging. As soon as the gums become tender, the medicine must either be entirely withheld, or used at longer intervals, and in smaller quantity. The effects of the mercury, however, should be steadily maintained, in a gentle form, for several successive weeks, otherwise the disease will be sure to reappear, or to resume its original character. The local treatment should be of the mildest description. The sore, washed several times a day with tepid water and soap, is kept constantly covered with scraped lint, wet with a weak solution of chlorinated soda, creasote, nitric acid, or compound tincture of myrrh and aloes. In some instances I have derived great advantage from the use of lime-water, containing two grains of bichloride of mercury and the same quantity of opium to the ounce. When there is much inflammation in the parts around the sore, warm water-dressing, or an emollient poultice, medicated with Goulard's extract, will afford great relief. For a similar purpose tincture of iodine may sometimes be advantageously used. An ointment composed of two grains of arsenious acid and an ounce of spermaceti ointment occasionally acts almost as a specific. Now and then great benefit accrues from local mercurial fumigation. As soon as the ulcer assumes a healthy granulating aspect, the best application is the opium cerate. The nail should be well trimmed, but evulsion is never necessary, except when the nail is devitalized or otherwise seriously diseased; nor is it proper to amputate the affected part, unless, after the cure is effected, it is found, by its bulk or unseemliness, to interfere with the convenience and comfort of the patient.

SECT. I.—SUPERIOR EXTREMITY.

I. AFFECTIONS OF THE HAND AND FINGERS.

The hand and fingers afford frequent opportunities for surgical interference, on account of deformities which not only greatly mar their beauty and symmetry, but seriously impede the exercise of their functions. These defects may be either congenital or acquired, being the result of various kinds of diseases and accidents, par-

ticularly paralysis and burns. The principal malformations met with here are, deficiency or redundancy of parts, a webbed condition of the fingers, and organic contraction of the muscles and palmar aponeurosis, constituting a species of distortion analogous to clubfoot.

CONGENITAL IRREGULARITIES OF THE FINGERS.

A *deficiency* in the number and size of the fingers is occasionally observed, one or two being entirely wanting, or they may be so stunted as to give the hand a very singular, unseemly appearance. In a case recently at my clinic, the fingers were all very short and stumpy, each being deficient in a phalanx. They were connected together by thick webs, smooth on the palmar surface, but rough and grooved on the dorsal, and were provided each with an excellent, well-shaped nail. The thumb was small, but natural, and had no membranous attachment to the index finger. The person, a member of the medical profession, enjoyed a very good use of the limb.

In some cases there are only two fingers with a thumb; and I have seen one example in which there was but one. The members, under such circumstances, may be of the natural shape and size, or they may be variously changed in their appearance, being generally thick and clumsy, or more or less contracted and stumpy. Occasionally they have a bulbous, knotty look, as if the umbilical cord had been twisted around them, and thus interrupted their natural growth. The thumb, I believe, is rarely affected in these mishaps. In a case lately under my observation each hand had four fingers but no thumb.

A *supernumerary* finger is uncommon, while it is by no means rare to see an additional thumb, as in fig. 724. Such a freak is occasionally met with on both sides; and several cases have come under my observation in which each hand had a supernumerary thumb, and each foot a supernumerary toe, the individuals being, in other respects, perfectly well formed. Occasionally this redundancy of parts is associated with great stature, as was the case in the giant of Gath. Sometimes the occurrence is hereditary. An additional finger usually exists in connection with the little finger.

Fig. 724.



Supernumerary Thumb.

Forster has recorded a case of nine fingers in the same hand; Saviard one of ten; Voight one of thirteen. Annandale saw a woman who had six fingers and two thumbs on each hand. These malformations are usually associated with a similar condition of the toes. An instance of double hand is occasionally witnessed.

The supernumerary member is generally a good deal smaller than the normal one, but well-shaped, and furnished with an excellent nail. Occasionally it is bulbous, knobby, curved, and very unseemly. Its attachment may be purely cutaneous, but in most cases it will be found to be through the medium of a separate joint, having a distinct synovial membrane.

Fig. 735.



Webbed Fingers.

Congenital irregularities of the fingers and toes are occasionally associated with other malformations, as harelip, cleft palate, bifid spine, clubfoot, and hydrocephalus. In a case which I recently saw with Dr. Bournonville there was a double thumb on one side, with a stunted thumb, hand, and forearm on the other, and

an imperforate anus, the rectum opening into the vagina.

A deficiency of fingers is, of course, an irremediable affection. If the person belongs to the higher ranks of society, something may be done to supply it by the

adaptation of artificial substitutes, secured to a glove, which, when worn, as it readily may be in company, shall hide the defect.

Any supernumerary piece that may exist is readily taken away by a very simple operation, care being taken to leave a sufficiency of integument to cover the wound, and to remove the part close to its attachment. When the finger is adherent by a narrow cutaneous pedicle, the best plan is to throw a ligature around its base and snip it off, as this will effectually prevent hemorrhage. I have seen two cases in which, a portion of the proximal phalanx being left, an unseemly projection remained, not at all creditable to the skill of the surgeon. The operation may be done within a few weeks after birth; if neglected until the person attains the age of manhood, he will be very apt to grow indifferent about it.

A *webbed* condition of the fingers, fig. 725, is easily remedied by passing a bistoury vertically from below upwards, through the redundant fold, and, after having removed what is superfluous, tacking the edges of the wound together by several points of the interrupted suture, or allowing it to heal by the granulating process. The fingers are afterwards supported upon a carved splint, lint, spread with simple cerate, being interposed between them, to prevent readhesion.

Instead of the above procedure, which I prefer to any other, some surgeons adopt a method practised by Liston, piercing the web at its proximal extremity with a bistoury, inserting a foreign body, as a piece of India-rubber cord, into the wound, and dividing the remainder of the web as soon as the edges of the orifice thus made are completely cicatrized. The chief advantage of this plan is that there is less danger of reunion between the two opposing surfaces than in the more ordinary method; its disadvantage is that it is more troublesome and tedious.

WOUNDS OF THE HAND AND FINGERS.

Wounds of the hand and fingers present themselves in a great variety of forms, as incised, lacerated, contused, punctured, and gunshot, and require essentially the same kind of treatment as similar lesions in other regions of the body. After the removal of foreign matter, their edges should be carefully approximated by suture and adhesive strips, when the parts should be supported upon a well-padded splint, extending from the inferior third of the forearm to the ends of the fingers, so as to place the wrist and phalangeal joints in the most easy and quiet position. If the fingers are fractured, the affected members may be placed in a hollow pasteboard splint. Unless the bones are comminuted and the soft structures extensively lacerated, it would be improper, as a general rule, to amputate. Most cases will do well under simple treatment. Even when a joint is pretty freely laid open, provided the articular cartilage has not sustained any serious injury, an attempt should always be made to save the parts. The same principles are strictly applicable to wounds of the carpus and metacarpus, involving the bones. Extraordinary recoveries often occur, especially in young, healthy subjects, in injuries of these parts under circumstances apparently of the most adverse character.

Wounds of the hand occasionally bleed very profusely, from involvement of the palmar arch, and, as the affected vessels are generally deep-seated, the hemorrhage is often checked with difficulty. The proper plan always is to enlarge the wound very freely, as early as possible, as a preliminary step, and to apply two ligatures, as a safeguard against the recurrent circulation. It is folly, in such a case, to tamper with the comfort and welfare of the patient by the use of compression, whether direct or indirect, if the vessel is of any considerable size, as the bleeding will be sure to return whenever the mechanical support is taken off; and in this way quarts of blood may be lost before relief is finally afforded. Ligation of the radial and ulnar arteries will be equally unavailing, for blood will still be sent to the wound by the interosseous branch, and, even if this also were secured, the probability is that the bleeding would still go on, especially if some time has elapsed since the occurrence of the accident, owing to the numerous and intricate anastomoses. We occasionally hear of cases in which the brachial artery has been tied for the arrest of hemorrhage of the palmar arch; but such a procedure is only justifiable when there is great swelling in the parts, obscuring the site of the bleeding vessels, and rendering operative interference extremely difficult and painful. The advice of John Bell, in his *Principles of Surgery*, in regard to the treatment of wounded arteries in

general, cannot be too strongly enforced here: "Meet the danger boldly, and don't be afraid to look your enemy in the face."

When the hand is greatly swollen and inflamed, as it often is in these cases after the lapse of several days, an effort should be made to arrest the hemorrhage by acupressure, or percutaneous ligation, as it may be extremely difficult, if not utterly impracticable, to expose the bleeding vessel, and tie it in a satisfactory manner, owing to the softened and confused condition of the tissues.

Sometimes a portion of a finger is torn off along with one of its tendons and, perhaps, also a portion of the fleshy belly of the corresponding muscle. If the two last bones are seriously involved, it will be best to amputate at the metacarpophalangeal articulation, otherwise an attempt should be made to save the finger, although it should turn out, as it will be likely to do, to be permanently stiff.

The most suitable application in most cases of wounds of the hands and fingers is cold water, with the addition, if there be much contusion or laceration, of a little alcohol and laudanum. The dressings must not be disturbed too often, as such a procedure generally materially impedes the reparative process.

In cleaning a fresh wound of the hand and fingers, the patient often experiences excessive pain from the use of cold water, especially if he is of a nervous, irritable temperament. For this reason, the fluid should always be tepid, and it may even be proper, under such circumstances, to dispense with cold water-dressing altogether for several hours after the receipt of the injury.

Punctured wounds of the hands and fingers are often followed by distressing neuralgic pains and atrophy of the muscles, attended with great coldness of the surface, a sense of numbness, and stiffness of the joints. The immediate cause of these occurrences is the injury of some nerve from the prick of a needle, pin, scissors, splinter of wood, or piece of glass. The pain is frequently periodical, recurring once a day or every other day in regular paroxysms, often of the most violent character. It generally darts about in different directions, but in many cases it is confined to the seat of the original injury, and is of a dull aching, gnawing, or boring nature, and accompanied with exquisite morbid sensibility of the skin. Occasionally the pain extends as high up as the top of the shoulder, and the whole limb is cold, numb, and wasted. The constitution often suffers very severely, especially if the patient is of a strumous predisposition, or of a nervous, excitable temperament, or if the health happened to be much impaired at the time of the accident. Obstinate neuralgia of the fingers sometimes occurs in sempstresses, type-setters, shoemakers, and persons of similar occupation, from excessive fatigue incurred in the exercise of their particular vocation.

The treatment of such lesions is seldom very satisfactory. The general health, if disordered, must be corrected; and quinine, strychnia, and arsenic freely given when the neuralgia assumes a periodical type. The most suitable topical remedies are the hot and cold douches, leeches, veratria ointment, saturnine lotions, aconite, and chloroform liniments, with hypodermic injections of morphia. The parts must be kept at rest in an easy, elevated position, well protected from cold. Change of air is often very beneficial. Excision of the injured nerve is sometimes the only thing that affords permanent relief. Any vicious cicatrice should always be promptly removed.

HYPERTROPHY OF THE FINGERS.

Hypertrophy of the fingers, although uncommon, is now and then observed; generally as a congenital vice, but sometimes as an acquired one. It usually affects several fingers, either simultaneously or successively, the others remaining sound. All the component structures, hard as well as soft, are equally involved, and the result is that there is often great and inconvenient deformity, the parts being heavy, cumbersome, and, perhaps, nearly twice as thick and long as in the natural state. The affection, of the true nature of which we are ignorant, is occasionally hereditary, and it has also been observed in several members of the same family. The treatment consists of systematic compression and sorbefacient applications, as the tincture of iodine, and the ointment of iodide of lead. If these means fail, as they generally do, and the enlarged member is not only useless, but unseemly and inconvenient, the only resource is amputation.

CONTRACTION OF THE HAND AND FINGERS.

Permanent contraction of the thumb and fingers from rheumatism, burns, paralysis, and other causes, is not uncommon, and is liable to be attended with the most distressing deformity and inconvenience. Such a condition is sometimes the result of a congenital vice, as in fig. 726, from one of my clinical cases. The distortion may exist in various degrees, and may be occasioned simply by a contraction of the tendons, of the palmar aponeurosis, or of a diseased cicatrice, or all these structures may be involved simultaneously, as is, perhaps, in fact, most generally the case. The nodular tissue left by burns and scalds has an astonishing contractile tendency, which often resists the most ingenious efforts of the surgeon to overcome it, and which, in time, is capable of producing the most horrible deformity, the fingers being bent like claws, deeply imbedded in the substance of the hand, or firmly united to one another. In paralysis, the fingers are frequently permanently flexed, in consequence of the shortened condition of the tendons of the flexor muscles, while the extensors are elongated, and completely deprived of their functions.

The immediate cause of these contractions, or the nature of the structures on which they directly depend, can be determined only by a careful examination, and the result must, of course, govern the treatment. The shortening occasioned by rheumatism, if existing in a high degree, will hardly be amenable to any remedial measures, however judiciously employed; it is only in the milder and more recent cases that much benefit need be looked for. The use of colchicum, assisted by calomel and opium, and the application of iodine and anodyne liniments, are the means chiefly to be relied upon. When the disease has been deprived of its acuity, an attempt may be made to break up the adhesions within the joints, and to restore the contracted muscles to their proper length, by gentle flexion and extension, or passive motion, the cold douche, and sorbefacient lotions, together with the splint and bandage, to maintain the hand constantly in a straight position.

When the deformity is occasioned by permanent shortening of the muscles, or tendons, however induced, tenotomy is of questionable propriety, experience showing that, although the operation may relieve the distortion, the patient never regains any material use of the affected part; on the contrary, indeed, he is generally made worse by it. Hence, the judicious surgeon should long hesitate before he undertakes a procedure likely to be followed by such a result. In particular should this be the case when all, or nearly all, the fingers are involved; for it has happened, under such circumstances, that what little use of the hand the poor patient still possessed, was entirely destroyed by the division of the tendons, their ends refusing to unite. When one finger only is concerned, and the object is to relieve an ugly and inconvenient deformity, no objection whatever can be urged against the operation.

It will thus be seen that there is a remarkable difference between tenotomy of the hand and fingers and tenotomy of the feet. In the latter, the ends of the divided tendons always unite with great promptness, so that the patient, if the case be well managed, is sure, in time, to acquire a good use of his extremity; in the hand, fingers, and forearm, on the contrary, there is rarely, if ever, any perfect reunion, and the consequence is that the operation, so far as the functions of the limb are concerned, is a complete failure. The cause of this difference seems to be the existence of a larger amount of synovial fluid in the sheaths of the tendons of the superior extremity than in those of the inferior, and the greater amount of space which intervenes between these structures, when divided, in the former than in the latter of these situations.

When the deformity is dependent upon the contraction of the *palmar aponeurosis*, it may generally be readily rectified by the free division of the resisting parts by a subcutaneous operation with a delicate, sharp-pointed tenotome. These parts are well displayed in fig. 727. The aponeurosis may, if necessary, be cut completely across where it covers in the palm, and any of its digital slips that may seem to be

Fig. 726.



Contraction of the Thumb.

at fault may then be successively traced out and severed. The after-treatment demands great attention. The hand and fingers must be enveloped in a bandage, and then carefully bound upon a well-padded carved splint, frequent washing, friction, and passive motion not being neglected.

Fig. 727.



Contraction of the Palmar Aponeurosis.

Fig. 728.



Vicious Cicatrices of the Fingers.

Deformity of the hand and fingers arising from the *vicious cicatrices* of burns and scalds, as in fig. 728, seldom admits of satisfactory relief. When the inodular tissue presents itself in the form of narrow bridges, it may be completely excised, and the wound approximated by suture; or the bands may be cut across at different points, and the gaps healed by granulation, the limb being maintained in the extended posture during the cicatrizing process, as well as for some time after, in order to prevent a recurrence of the contraction. When the cicatrice involves a large surface, nothing short of its entire removal, and the transplantation of a flap of healthy integument, will be likely to answer any useful purpose. The graft might be borrowed from the other arm, or from the chest, as might seem most feasible.

CONCUSSION AND CONTUSION OF THE FINGERS.

These affections, of which I have witnessed numerous cases, are generally the result of falls, in which the finger is doubled under the hand, or struck against some hard body, as the floor or pavement. Sometimes the effects of concussion predominate, at other times those of contusion; and there are cases in which both are conjoined with sprain, caused by the sudden and forcible extension of the ligaments of some of the articulations. However this may be, the affected finger feels not only painful but benumbed and heavy; occasionally an unpleasant tingling is experienced. Considerable swelling often ensues, and for days, if not weeks and months, the patient is unable to use the affected member. In some instances the suffering is confined to one particular spot, perhaps not more than two or three lines in diameter; at other times the chief trouble is in one of the joints, manifesting itself, in either case, simply in a little soreness or tenderness, with some degree of numbness. The affection is most liable to prove obstinate and troublesome, if, at the time of the accident, there is impairment of the general health, or a dyspeptic condition of the system, with disorder of the secretions. Indeed, the secondary effects are often, in this condition, much more annoying than the primary. In some instances, the whole finger and even a portion of the hand, become permanently cold, enfeebled, and wasted.

The treatment is at first strictly antiphlogistic, the principal remedies being leeches, saturnine lotions, and tincture of iodine. When the case is chronic, the hot and cold douches will be serviceable, conjoined, when the general health is deranged, with a mild alterant and tonic course, exercise in the open air, and a properly regulated diet. Vesication is seldom of much benefit. When the pain or tenderness depends upon deep-seated inflammation, recourse may, with advantage, be had to subcutaneous scarification of the periosteum.

CLUBHAND.

The hand is sometimes distorted in such a manner as to present an appearance analogous to clubfoot, especially the variety called *varus*. Hence it is generally

termed clubhand, an appearance well seen in fig. 729. The affection is occasionally congenital, but in the great majority of cases it supervenes upon paralysis, or loss of antagonism in the two classes of muscles. The alterations are characteristic. The hand is inverted, the internal margin inclining strongly upwards, the fingers are more or less flexed, and the carpus seems to be partially dislocated from the radius and ulna, forming a marked projection at the inner border of the limb. Sometimes the hand is turned in the opposite direction, in imitation, as it were, of valgus, or the everted variety of clubfoot. However this may be, the affection is not unfrequently associated with distortion of other parts of the body, and usually occurs in persons of a debilitated frame, or in such as are particularly prone to suffer from nervous diseases. Very recently, I saw a case in which both hands and both feet were clubbed, the patient being a child three months old.

The treatment consists in the removal of the exciting cause, and the improvement of the general health. To accomplish the latter, a course of chalybeate tonics, exercise in the open air, and the daily use of the cold shower-bath will be the best means. Electric currents may occasionally be passed through the affected limb, and the surface may be frequently rubbed with some stimulating lotion. If the case be recent, and the deformity comparatively slight, forced extension, repeated several times a day, and long-continued, will sometimes effect a cure. When this fails, an attempt may be made at rectification by the employment of appropriate apparatus, similar to what is used in the milder forms of clubfoot; but, under opposite circumstances, division of the affected tendons alone will enable us to relieve the distortion, although a long time will elapse before there will be much improvement of the functions of the parts. The muscles whose section will generally be necessary are the long palmar, the flexors of the radius and ulna, and the superficial flexor of the fingers, the knife being introduced with the greatest caution, lest injury be inflicted upon the arteries and nerves of the forearm.

Fig. 729.



Clubhand.

REMOVAL OF RINGS FROM THE FINGERS.

Serious difficulty is sometimes encountered in removing rings from the fingers, either in consequence of tumefaction caused by their pressure, or of the increased size of the member, as when the ring, put on early in life, has not been taken off for a long time. Most generally, however, it arises from a small ring being forced, either accidentally or designedly, upon a disproportionately large finger. If relief be not promptly afforded, severe inflammation will ensue, terminating in ulceration and, perhaps, even in gangrene. Several methods may be adopted for effecting this object. In the first place, the hand may be immersed in ice-water, to cause contraction of the finger; or the finger may be tightly bandaged, and then held in ice-water. If these expedients fail, a piece of pack thread, or saddler's silk, well waxed, should be closely and firmly wrapped around the finger, beginning at the distal extremity, and extending as high up as the ring. The thread is then passed by means of a small blunt bodkin under the ring, when, drawing it very tightly, the ring is gradually forced down as the ligature is untwisted. Should this plan also prove fruitless, the only other resource is to cut the ring in two with a file, or a delicate pair of bone-nippers.

WHITLOW.

This disease, technically called paronychia, and vulgarly felon, is an affection of the thumb or finger, commencing in inflammation, which soon terminates in suppuration, and sometimes even in gangrene. It is distinguished by the great severity of its pain, and exhibits itself under two varieties of form, the superficial and deep, the former being limited to the skin and cellular substance, whereas the latter involves not only these structures, but also the tendon, periosteum, and bone.

Whitlow is very rare in children, and I do not remember ever to have met with it in infants. It is most common between the ages of twenty and thirty-five, but is

also sufficiently frequent in elderly persons, cases occasionally occurring after the eightieth year. Females are more subject to it than men, and the probability is that certain occupations predispose to its development. Thus, washerwomen, and other persons who have their hands habitually immersed in water, are particularly obnoxious to it. At times, the disease is epidemic, as happened a few years ago in various sections of the Union, when an unusual number of cases, in both sexes, and of different ages, fell under my observation and treatment. An affection similar to whitlow is occasionally met with in the toes.

In the superficial forms of whitlow, the inflammation is generally seated immediately around and beneath the nail, commencing either at the side of the finger, upon its dorsal surface, or at its extremity. Without much, if any, swelling, the part is of a dusky reddish aspect, tender on pressure, and exquisitely painful, throbbing violently and incessantly, and causing more or less constitutional disorder. In from two to three days after these phenomena present themselves, matter is observed in the finger, lying immediately beneath the epidermis, which is elevated into yellowish vesicles at the side and back of the nail; in many cases, pus is also situated below the nail, especially at its posterior extremity; and sometimes, again, it is found chiefly, if not exclusively, in the cellular substance immediately beneath the true skin. The inflammation generally extends some distance up the finger, and occasionally even over a considerable portion of the hand, which may be a good deal swollen, stiff, and painful. Not unfrequently, a reddish line, indicating the course of an absorbent vessel, is seen running along the limb, as high up, perhaps, as the axilla.

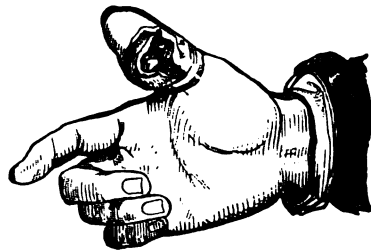
In the deep-seated variety of whitlow, the inflammation involves all, or nearly all, the structures of the finger, and is frequently followed by the destruction of one or more of the phalanges. The pain is of extraordinary severity, depriving the patient of sleep for days and nights together; throbbing, tensive, and diffused, often extending as high up as the elbow and even to the shoulder; steady and persistent, but greatly aggravated by depending position, and only subsiding with the evacuation of the inflammatory deposits, or the death of the part. The swelling also is great, sometimes enormous, involving both finger, hand, and wrist; the skin is red and œdematous, having a puffy, erysipelatous aspect; and the whole limb is often stiff and useless. If the morbid action is not speedily checked, matter will form deep among the tissues, in the connecting cellular substance, within the sheaths of the tendons, and beneath the periosteum, and, spreading in different directions, will cause extensive havoc, burrowing along the finger and hand as far up, perhaps, as the wrist and forearm. In neglected cases, gangrene occurs, followed by sloughing of the tendons, and exfoliation the phalanges. The external characters of whitlow are well illustrated in fig. 730, while the effects which the disease often exerts upon the bones are displayed in fig. 731.

Whitlow, in its more severe forms, is always attended with well-marked constitutional disturbance. The patient, tortured with pain, is feverish, and unable to sleep; his appetite is lost; his head, back, and limbs ache; the face is flushed, and the pulse is strong, hard, and frequent. In some cases delirium is present.

How this disease is produced, or what its real character is, is still a mooted question. The most plausible conjecture is that it is a bad form of inflammation, not unlike erysipelas or carbuncle, occurring in a constitution more or less depraved, in consequence of a

disordered state of some of the secretions, particularly those of the digestive apparatus. In the female, it is occasionally associated with irregularity of the menses, but whether as an effect or coincidence, is undetermined. My belief is that it is impossible for whitlow to occur in a sound constitution. I should, therefore, infer that it is a peculiar form of inflammation with an inherent tendency to suppuration.

Fig. 730.



Paronychia of the Thumb.

Fig. 731.



Necrosis of the Bones in Whitlow.

There is no disease with which paronychia is likely to be confounded. Its peculiar situation, the severity of the pain, the dusky appearance of the skin, and the speedy occurrence of suppuration, will always enable the practitioner to distinguish it readily from other affections. Boils and carbuncles never occur upon the extremity of the fingers.

In the *treatment* of this affection very little is to be expected from the employment of abortive measures, since, as has already been stated, its tendency is always to pass into suppuration. In its milder forms, and earlier stages, the morbid action may occasionally be limited by a brisk cathartic, and the application of the undiluted tincture of iodine, made two or three times in the twenty-four hours, with an emollient poultice, wet with laudanum, in the intervals. When the swelling is very considerable, leeches may sometimes be advantageously used in the vicinity of the focus of the inflammation, and, in such an event, I have also occasionally experienced great benefit from thorough vesication with cantharidal collodion. To relieve the excessive pain, opiates must be given in full and sustained doses, either alone or in union with antimonial and saline preparations.

The above means are, however, at best, only palliative, relieving pain, and, perhaps, limiting morbid action, but not eradicating it. The great and indispensable remedy, after all, is the knife, employed early and boldly, not expectantly and timidly; the incision being long and deep, the edge of the instrument grating upon the bone. Suppuration is, if possible, anticipated, and structure thus saved. When the matter has been permitted to burrow, numerous openings may be necessary, and extensive mischief may take place, before we may be able to reach the point of repair, the fingers, hand, and wrist long, if, indeed, not permanently, remaining stiff, painful, and unserviceable. Dead bone is removed as soon as it is easily separable, the periosteum being as little interfered with as possible, and amputation always avoided, experience having shown that a new phalanx is sometimes formed, and that, even when this does not happen, the boneless finger will be both useful and sufficiently seemly. When the violence of the inflammation has subsided, the parts should be kept constantly wet with some anodyne and astringent lotion, alcohol and laudanum, or a solution of opium and hydrochlorate of ammonia. At a still later period, they should be well douched, first with warm, and then with cold water, dried, and rubbed with soap liniment or camphorated mercurial ointment, and supported with a bandage, each finger being enveloped separately. These directions may seem trivial, but any one who has had whitlow in his own person, or who has seen much of the disease in others, will not fail to appreciate their value.

SYPHILITIC AFFECTIONS OF THE FINGERS.

Under the terms syphilitic dactylitis, syphilitic panaris, and gummy syphilis, have lately been described certain affections of the phalanges of the fingers, due to hereditary syphilis. An excellent account of the disease was published in 1871, by Dr. R. W. Taylor, in the *American Journal of Syphilography and Dermatology*. He considers the malady very uncommon, a statement with which my experience is altogether at variance. Hardly a winter has elapsed for years in which we have not had cases of it at the College Clinic, and I have also met with a considerable number of examples in private practice.

The disease, according to my experience, is most common in children, from three to seven years of age, but it is occasionally met with in infancy and early youth. In several of my cases it came on soon after birth. It frequently coexists with syphilitic affections in other parts of the body, as the hands and feet, the superficial bones, the subcutaneous and intermuscular connective tissues, skin, nose, mouth, and anus. The disease generally begins in one of the phalanges of the fingers, from which it gradually extends to the other bones, as well as to the intermediate joints, the affected member being at length transformed into a large, shapeless mass. In its character it is essentially identical with the nodes so often witnessed on the tibia and on the skull in the adult. The gummy matter, the chief morbid product, is generally deposited both in the areolar tissue of the bone and upon its outer surface underneath the periosteum. As it accumulates, it gradually causes expansion and softening of the affected structures, soon followed by great swelling, and eventually by ulceration, the resulting sore being always of a foul, rebellious character, attended with more or less profuse sanguinolent and fetid discharge. The discoloration varies

from light pink to deep red, and even purple. The attendant pain is usually slight, especially in the earlier stages of the disease. In some cases, however, it is quite severe throughout. The general health is frequently much impaired. The child is pale, feeble, and emaciated, although, now and then, he is fat and plump, with an excellent appetite, and, in every respect, save the local disease, well conditioned.

The diagnosis of syphilitic dactylitis is based upon the history of the case, the age of the patient, the coexistence of similar disease in other parts of the body, and the peculiarly distorted appearance of the affected parts.

The most important internal remedies in the treatment of this affection are the iodides, either alone, or, what is preferable, in union with a minute quantity of bichloride of mercury. Chalybeate tonics are indicated in case of anemia, flatulence, and indigestion, along with nutritious food and drink. The local measures most likely to be beneficial are dilute tincture of iodine, emollient poultices, leeches, and free incisions, extending down to the bone. When the disease assumes an open form, deodorizing and soothing applications must mainly be confided in. Amputation will be necessary when the affected member is hopelessly involved in the morbid action.

ANEURISM AND NÆVUS OF THE FINGERS.

The fingers are liable to varicose aneurism, consisting, as the term implies, in an enlargement of the arteries and veins, superficial as well as deep; usually commencing before birth, and progressively augmenting until, as seen in fig. 732, it occasions great deformity and inconvenience. In some instances, the disease

extends over the hand, the forearm, and even the arm, as high up as the axilla. The fingers are of a purple color, of a soft, spongy consistence, nodulated, and several times the natural bulk. They pulsate synchronously with the heart, and are readily diminished by pressure, but immediately regain their former size when the pressure is discontinued. Dissection shows the vessels to be not only enlarged, but also tortuous, thickened, and indurated, with a predominance, at one time, of the arterial, and, at another, of the venous element. The disease is rarely attended with pain.

The treatment of this affection is unsatisfactory, as it has hitherto proved refractory under every variety of local

measures. So long, therefore, as it causes no serious inconvenience, or evinces no disposition to increase, no attempt should be made to interfere with it. A spontaneous cure is, of course, never looked for. When the enlargement is limited to several arterial trunks, ligation may be employed, the varicose veins being afterwards treated by injections with subsulphate of iron. If the deformity is very great, nothing short of amputation will suffice.

A very rare case of traumatic aneurism of the internal artery of the ring-finger has been described by Mr. Thomas Annandale, of Edinburgh, in a woman forty-one years of age, who nine weeks before had pricked the vessel with a sharp hook. The tumor, about the size of a small marble, pulsated synchronously with the heart, and a distinct thrill could be felt on touching it. The proper treatment of such a tumor is to lay it open and to tie both ends of the vessel.

Nævus of the fingers is uncommon. It is easily distinguished by its peculiar florid appearance, by its history, and by its slight projection beyond the surrounding level. In a case under my care at the College Clinic, in a child three months old, in which the disease occupied the dorsal and lateral aspects of the middle finger, a satisfactory cure was effected by strangulation with three pins, introduced lengthwise, each being encircled by a stout ligature.

Fig. 732.



Varicose Aneurism of the Fingers.

BURSAL SWELLING OF THE FINGERS.

The subcutaneous bursae, naturally situated upon the dorsal aspect of the joints of the fingers, so admirably described and delineated by Schreger, are, like other serous structures, liable to inflammation and its consequences. The most common causes are wounds, bruises, and contusions, but the disease may also arise from a gouty, rheumatic, or syphilitic state of the system. The usual symptoms are, a circumscribed swelling, pain, discoloration, and increased heat, with impairment of the function of the corresponding articulation, and more or less involvement of the surrounding vessels. If the morbid action is not soon arrested, suppuration follows, with marked aggravation of the local distress. From the proximity of the disease to the digital joint, the affection is very liable to be mistaken for ordinary symptoms.

In the chronic form of the disease, the sac is thickened by interstitial deposits, and there is often a considerable effusion of serum; the movements of the joint are impeded, and the finger presents an unseemly aspect. Enlargements, not unlike flattened corns or bunions, sometimes form in the situation of these pouches, and may be a source of serious inconvenience, if not actual suffering. Similar formations are liable to occur on the palmar aspect of the fingers, especially in hard-working mechanics, as carpenters, masons, stone cutters, and blacksmiths.

Mr. Holden, of London, has described a peculiar hernia-like protrusion of the synovial membrane of the sheaths of the flexor tendons of the fingers. It occurs as a small body, from the size of a pin's head to that of a pea, of irregular shape, firm to the touch, and accompanied by a reddish substance, of the consistence of jelly. It is liable to become painful, and to interfere with the free movements of the fingers.

The treatment of these different affections must be conducted upon antiphlogistic principles; by rest, leeching, iodine, and saturnine lotions. If matter form a free and early incision must be made. In chronic cases nothing generally answers so well as a series of little blisters.

PHLEGMONOUS INFLAMMATION AND ABSCESS OF THE HAND.

A very distressing form of inflammation, closely resembling whitlow, occasionally occurs in the hand, generally in the palm, in consequence of external violence, as a puncture or contusion. It is deep-seated, commencing either in the palmar aponeurosis, in the subaponeurotic areolar tissue, or in the sheaths of the tendons. However this may be, all these, as well as the other structures, both hard and soft, rapidly become involved in the morbid action, which often spreads over a large extent of surface. The symptoms are those of violent inflammation; the parts are excessively swollen, of a dark red or livid color, and the seat of exquisite pain, of a throbbing, pulsatile character. The fingers and wrist are stiff and tumid, and there is always high constitutional excitement, not unfrequently attended with intense headache and even delirium, especially when matter is about to form.

The treatment, to be effective, must be prompt and energetic. Blood must be taken freely from the part by leeches, or even from the arm, if the patient be at all plethoric; the bowels must be thoroughly evacuated, and vascular excitement must be subdued with depressants. The hand, elevated, and kept at rest, is surrounded with cloths wet with a strong solution of acetate of lead and laudanum, and no time is lost in letting out pus. If this be neglected, the worst consequences are to be apprehended, as necrosis of the bones, ankylosis of the joints of the fingers, and permanent contraction of the tendons. Occasionally mortification occurs.

SCRIVENER'S PALSY.

Under this appellation may be described a peculiar affection, long known as writer's cramp, and consisting in a partial paralysis of certain muscles of the hand and fingers, which, in consequence, are deprived of their co-ordinating power. Although it is most common among persons who are constantly occupied in the use of the pen, it is not limited to them, as it also occurs among shoemakers, milkmaids, musicians, composers, and sempstresses. It has its origin generally in fatigue arising from long-continued exertion of the muscles of the hand and fingers concerned in holding

the pen, in playing upon instruments, and in performing various other delicate movements.

Among the earlier symptoms of the complaint, is a sense of fatigue and numbness of the thumb and forefinger, or of actual cramp, which compels the person to throw down his pen, and to rest himself. On attempting to extend the affected structures, they are found to be stiff, crippled, and perhaps even painful. Rest affords temporary relief, and the hand, in consequence, always feels much better in the morning after a sound and refreshing sleep. The affection is usually progressive, developing itself gradually, so that generally a considerable length of time elapses before it attains its height. In its worst forms it involves not only the muscles of the fingers, but also those of the hand, and even those of the forearm, the arm, and shoulder, causing more or less lameness, pain, and numbness in the entire limb. When the affection has reached this point, the pen cannot be held beyond a few minutes at a time without severe suffering; the muscles soon become cramped and stiff, and the writer is obliged either to desist from further effort, or to wrap up his pen in his handkerchief in order to afford him a fuller grasp. Thus the case progresses, from bad to worse, until, at length, complete inability ensues.

The sensation experienced in the affected parts varies much in different cases; sometimes it is a numbness, sometimes a tingling, smarting or burning. Occasionally the thumb and fingers feel as if they had been sprained. Sometimes the principal distress is situated in the knuckles of the fingers, at the extremity of the metacarpal bones, in the wrist, or in the muscles of the forearm. In some cases the pain resembles that of rheumatism, in others that of neuralgia. Sometimes it is sharp and darting, at others dull and aching. However this may be, numbness, tingling, or burning is always a prominent symptom when the affection has attained full development, the muscles are then also wasted, and the fingers soon become cold, stiff, and almost insensible under the slightest exertion. These various sensations are liable to be aggravated by disorders of the general health, mental excitement, and damp states of the atmosphere. When the person is predisposed to rheumatism, gout, or neuralgia, the pain is often so great as seriously to interrupt sleep and comfort. Cases have been met with in which writing with the sound hand caused severe pain and fatigue in the muscles of the affected one. Aching of the spine has occasionally been observed as an accompaniment of the complaint.

The pathology of scrivener's palsy is not well understood. Judging from the cases that have fallen under my own observation, and from what I have experienced, at times, in my own person, I am strongly inclined to believe that it is simply a local nervous affection of the muscles of the thumb and fingers, originating in excessive fatigue, and eventuating finally in partial paralysis and atrophy. That the paralysis is not complete is shown by the fact that the affected parts may still be usefully employed in the ordinary concerns of life, as in eating, drinking, and various other manipulations. Solly and some others suppose that it has its origin in the cells of the gray substance of the spinal cord, and in support of this opinion it is asserted that the affection occasionally begins in the shoulder, arm, or forearm. Such instances, however, are manifestly exceptional, even if it be admitted that they are, which, however, is doubtful, genuine examples of scrivener's cramp. Some, again, as Brown-Séquard and Claude Bernard, suppose that the disease is due to reflex action, while Fritz and others consider it as a reflex neurosis. However this may be, it is seldom that any case, when fully established, is ever completely cured. In the worst case that I have ever seen the affection lasted for upwards of thirty years, with no material improvement from any of the various plans of treatment, local and constitutional, that were tried for its relief. Both hands were involved, the right first, and afterwards the left, the latter nearly in the same degree as the former.

The only hope of relief in scrivener's palsy is from early and efficient treatment. Naturally the first thing that suggests itself is total rest, not for weeks, but months, if, indeed, not for several years, of the affected parts. The hand and forearm should be supported in a sling, and daily douched, first with hot and then with cold water, after which they should be well rubbed with veratria ointment or some stimulating embrocation in order to give tone to the disabled muscles. Electricity, in the form of faradization, has been found useful and is worthy of trial, especially in obstinate cases. Shampooing is also serviceable. In cold weather the parts should be protected from the contact of the air. The hypodermic injection of morphia should be tried when the pain is localized at a particular spot. The general health must not

be neglected. Tonics, change of air, and a residence at the seashore, are often productive of great good. Quinine, iron, and arsenic must be used when the system is broken down, or the case is complicated with neuralgia.

When the disease is fully established artificial support is the only thing likely to be of any benefit. A celebrated journalist, now deceased, who often consulted me about his case, managed to write for several years, by using a pen the handle of which was made very large by surrounding it with silk, and grasping it with the thumb and fingers in a state of extension. In this way he could write for several hours a day, until, at length, he became completely disabled. He finally resorted to various mechanical expedients, with, however, hardly any benefit. In a case reported by Cazenave the spasms that interfered with the act of writing were controlled by compressing the muscles of the hand and forearm with a laced bracelet. Froschell refers to a case in which the man was enabled to write by placing the pen in a piece of wood pierced with holes, and grasped with the whole hand. A plan occasionally advantageously employed consists in securing the pen to the dorsal groove formed by the junction of the fore and middle fingers by means of rings, as represented in fig. 733. A somewhat similar contrivance, sketched in fig. 734, was devised by Mathieu, an eminent cutler of Paris, with this difference, that it was fastened to the thumb and forefinger. The object is to support these structures while their muscles

Fig. 733.



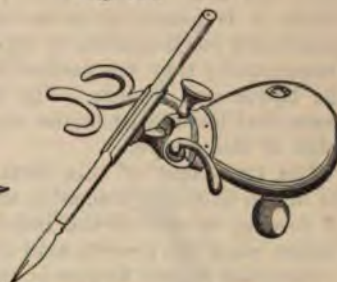
Apparatus for Scrivener's Cramp.

Fig. 734.



Mathieu's Apparatus for Writer's Cramp.

Fig. 735.



Velpeau's Apparatus for Scrivener's Cramp.

are kept in a passive condition. Velpeau suggested the use of a large penholder, consisting of a fluted, pear-shaped ball, designed to be grasped by the entire hand. This contrivance, which was afterwards modified by Mathieu, has often been employed with great comfort, and is one of the very best of the kind ever invented. Fig. 735 affords a good idea of its general appearance with the penholder attached to the smaller end of the ball.

Tenotomy holds out no prospect of relief in this disease. Dieffenbach utterly failed with it, and Stromeyer and Langenbeck met with only a very transient improvement.

TUMORS OF THE HAND AND FINGERS.

The thumb and fingers are occasionally the seat of various kinds of tumors, benign and malignant, interfering with their comfort and usefulness, and requiring removal. Both classes of affections are, however, very uncommon as primary developments. I was obliged, not long ago, to amputate the thumb of an elderly lady for a melanotic disease of twelve years' standing, and I have removed several fingers on account of epithelioma; but, of genuine primary scirrhus and encephaloid of the thumb and fingers, no example has ever fallen under my notice, and very few have been recorded by authors.

Among the benign tumors of the thumb and fingers, one of the most common is the *enchondromatous*, fig. 736, beginning early in life, in children of a stunted, rickety formation, and soon attaining so great a bulk as to interfere materially with the usefulness of the part. The growth, which is hard, tense, and incompressible, and which takes its rise in the osseous tissues, is often multiple, several masses affecting the same finger, or even the same bone. Now and then, nearly every finger suffers. Its volume varies from a pea to that of an orange. The formation is generally unattended with pain, the only inconvenience which it occasions being caused

Fig. 736.



Enchondroma of the index finger.

by its weight and size. If permitted to go on unrestrained, or if imperfectly removed, it may assume malignancy, but such an event is uncommon.

The diagnosis of the enchondromatous tumor is very easy, the history of the case, the absence of pain, and the peculiar form, density, and situation of the tumor, always sufficiently declaring its character.

The proper remedy is ablation, not of the tumor, but of the finger upon which it is situated. If the mass only is excised, there will inevitably be speedy recurrence, with a tendency, in all likelihood, to malignancy from rapid cell formation, the part being softer than originally, and growing

with unusual vigor. When the tumor involves the hand, a portion of that also must be sacrificed.

A *fibrous tumor*, hard, firm, dense, and inelastic, is occasionally met with in the hands and fingers. It ranges in size from a small pea to that of a hazelnut, is perfectly movable and free from pain, and is situated immediately beneath the skin, to which it is generally more or less closely adherent. The number of growths is sometimes considerable, as many as twenty having been noticed in the same person. Occasionally they are perfectly symmetrical, occupying similar positions both upon the hands and fingers. The cause of these tumors is unknown. In some of the cases that have fallen under my observation, they appeared to be due to a syphilitic taint of the system.

The treatment of this form of tumor must depend upon circumstances. When its origin is clearly traceable to the effects of syphilis, the most suitable remedy will, of course, be one of the iodides, in union with mercury. Excision can only be proper when the growth acts obstructingly.

Sarcoma of the fingers is very uncommon, but it may spring from the bones as a central or peripheral tumor, or, as occasionally happens, from the sheaths of the tendons.

A case of sarcomatous tumor of the thumb in a lady, forty-seven years of age, sent to me by Dr. Ward, of Bristol, recently came under my observation. The affection had made its appearance about two years previously around the nail, in the form of a little tubercle, which, as it enlarged, became the seat of heat, pain, and swelling, and ultimately broke out into an open sore, the seat of a constant, thin, sanious, and offensive discharge. The distal phalanx being removed, the member remained well for about six months, when the disease recurred in the articular extremity of the first phalanx, causing great expansion of the bone, and rendering further surgical interference necessary.

An *exostosis* of the thumb and fingers is very uncommon. Not long ago I met, in a young woman of twenty-one with a case, of such a growth under the forepart of the nail of the right thumb, where it had made its appearance nearly two years previously. It was of an irregular hemispherical shape, and about the size of a marrowfat pea. The only remedy is excision.

Entozoa in bone are extremely infrequent, and, so far as I know, there is only one instance upon record in which these parasitic animals were developed in the hand. The case, described by Professor Jüngken, of Berlin, occurred in a man, twenty-one years of age. The entozoa, which belonged to the cysticercic variety, occupied the first phalanx of the forefinger, the interior of which was expanded into a large cavity.

A *cystic tumor*, filled with serous fluid, or more or less solid material, is occasionally found upon the fingers, generally just beneath the skin, and is easily disposed of with the knife.

A few examples of *nerve tumor*, in the form of the subcutaneous painful tubercle of the hand, are upon record; and Dr. Robert W. Smith, of Dublin, has given two illustrations of the neuromatous tumor occurring on the digital branch of the median nerve of the index finger. The diagnosis of such formations is not difficult.

The painful nature and chronicity of the enlargement are always sufficiently characteristic of the disease. The only remedy is excision.

The *fatty tumor* of the hand is extremely rare. I have myself seen only one example, in a lady, sixty-five years of age, kindly sent to my Clinic by the late Dr. James Taylor, one of my former assistants. The tumor, about the size of an egg, was situated in the palm of the hand beneath the palmar aponeurosis, a process extending forward over the corresponding aspect of the ring finger. It had existed for twenty-two years. Its nature was sufficiently evident before it was removed.

In his "Surgical Observations" the late Dr. J. Mason Warren has given the particulars of two cases of adipose tumors, one of which was situated on the hand, while the other involved the first phalanx of one of the fingers, to which it clung so closely as to induce the belief, prior to amputation, that it was malignant. It lay in immediate contact with the bone, and the pressure exerted upon it by the tendons and fascia had imparted to it this deceptive appearance. The patient was a child. In a case of fatty tumor of one of the fingers, reported by Professor Bigelow, of Boston, the part so closely simulated a burse that it was punctured.

Terrible suffering and deformity of the thumb and fingers, with great impairment, if not total loss, of function, occasionally arise from *gouty deposits* in the phalangeal joints. The affection, of which the annexed sketch, fig. 737, from Garrod, affords

Fig. 737.



Gouty Deposits in the Joints of the Fingers and Bursae of the Elbow.

a good illustration, usually coincides with similar formations in other parts of the body, especially the elbow, knees, toes, and heel, and is evidently dependent upon the retention of the lithate of soda, the morbid material of gout, the kidneys being unable to eliminate it with sufficient rapidity. The fingers, at first merely stiff and painful, present a tubercle appearance, looking, as Sydenham expresses it, like a bunch of parsnips, and becoming ultimately completely immovable and useless. The substance upon which the deformity depends is originally of a soft, creamy consistence, and of a whitish, grayish, or dark color; but, by degrees, it assumes the solidity of chalk or mortar, so that, if several pieces coexist, the diseased joints sometimes rattle like bags of marbles. As the swelling augments, the concretions approach the surface, causing attenuation, and finally ulceration, of the skin, with a partial discharge of the characteristic material.

The treatment consists in rectifying, by appropriate diet, purgatives, colchicum, and alkalies, the peculiar state of the system upon which the formation of the lithic acid depends, and in removing, if necessary, by puncture and pressure, the inspissated matter from the affected joints. Amputation must not be thought of, unless the pain and deformity are excessive, and cannot be relieved in any other way.

2. AFFECTIONS OF THE ELBOW.

The large *synovial burse* which is interposed between the tendon and triceps muscle and the top of the olecranon, and which in some instances is multilocular, is liable to inflammation and great distention from the accumulation of its natural secretion, forming thus a swelling, occasionally of extraordinary size, at the poste-

rior and lateral aspect of the elbow. The parts are tender on pressure, and impart a peculiar crepitating, fluctuating sensation, which readily distinguishes it from other affections in this situation. The usual cause of the disease is external violence, although it sometimes arises spontaneously. Persons, as miners, for example, who lean habitually upon the elbow, are very subject to the disease. The morbid action may become chronic, or even pass into suppuration; and in cases of long standing the coats of the synovial bag are occasionally very much thickened and indurated. Now and then such a tumor contains loose fibroid bodies, resembling small melon seeds in appearance. Fig. 737 affords a good illustration of a burse filled with gouty matter.

The treatment is by leeches, blisters, and sorbefacient lotions, with rest of the parts, and an occasional purgative. If the accumulation of fluid is unusually great, an incision may be made, and the surface of the pouch mopped with dilute tincture of iodine. Matter should always be promptly evacuated.

The *lymphatic gland* situated immediately above the elbow, between the biceps and triceps muscles, is often enlarged in secondary syphilis, in conjunction with cervical adenitis and affections of the skin and mucous membranes, and generally speedily subsides under the application of a few leeches, tincture of iodine, and saturnine lotions. In tertiary syphilis the gland is occasionally affected with gummy deposits, eventuating in the establishment of an unhealthy abscess, filled with ill-elaborated pus. A free opening should be made, and the patient placed under appropriate constitutional treatment.

Anchylosis of the elbow is a frequent consequence of caries, dislocations, and fractures, and may present itself in various degrees, from the slightest stiffness to complete osseous immobility. The forearm is generally bent nearly at a right angle, but occasionally it is in a straight position, thus rendering it, in great measure, if not completely, useless for the ordinary purposes of life.

The treatment must depend upon the nature of the adhesions, as to whether they are fibrous or osseous. In the milder cases, the proper remedy is the laceration of the morbid connections by forcible flexion and extension with the aid of chloroform, regular passive motion being afterwards maintained to prevent relapse. Osseous union, if not too strong, may be broken up with the perforator, introduced subcutaneously; or, if the operation fail, or is contra-indicated, resection may be employed, a V-shaped portion of bone being cut out from the back part of the elbow, with a view of establishing a false joint.

Sometimes the ankylosis depends mainly upon osseous adhesions of the olecranon, the rest of the articulation partially retaining its integrity. In two instances of this kind I succeeded in effecting excellent cures by forcibly breaking this process; an operation which is usually not difficult in recent cases, as the osseous tissues are then always more or less softened.

The elbow-joint is sometimes rendered useless by the contraction of the brachial aponeurosis and of the tendon of the two-headed flexor muscle, in consequence of paralysis, rheumatism, or burns. The proper remedy consists in the division of the affected parts, the operation being performed in such a manner as not to interfere with the brachial artery, and extension being afterwards made with an angular splint, united by hinges, and worked by a screw. In this manner, the limb may often be restored to usefulness in a very short time, especially when there is no serious disease of the joint.

3. AFFECTIONS OF THE SHOULDER.

Wounds of the shoulder, of whatever character, must be managed upon the same general principles as similar injuries in other parts of the body. Several remarkable instances have been recorded in which the arm and scapula were suddenly torn off from the trunk, and yet the hemorrhage was so slight as not to require the ligature. The cases of Cheselden and La Motte have become classical. Frightful and extensive as were the wounds, the patients rapidly recovered without an untoward symptom. Although there is generally no copious bleeding in lacerated wounds, the possibility of such an event, upon the occurrence of reaction, should always dictate the propriety of securing the principal arteries.

Dr. Stephen Rogers, of New York, in 1868, brought forward eleven examples in which the arm along with the scapula was torn away from the trunk, the first being

that of Cheselden, in 1737. The bleeding in this case was so slight as not to require the ligation of any vessels, and the man made a prompt recovery. In Clough's case, the patient, a girl eleven years old, was well in two months. In Mussey's patient, no ligature was employed; less than a pint of blood was lost, and the recovery was complete in eight weeks. The case of James, in 1830, was of a similar nature. Scarnell in dressing a wound of this kind thought it necessary to excise the outer third of the clavicle, and he also, as a precautionary measure, tied the principal vessels, although little bleeding had occurred. The patient, a lad thirteen years old, was about in a fortnight. In the sixth case, reported by Braithwaite, there was hardly any hemorrhage until the main artery was disturbed with the forceps, when a violent gush of blood took place, and the ligature was at once employed. Prompt recovery occurred. In a case observed by Lizars, the outer half of the clavicle was torn away along with the arm and scapula; and, although there was no hemorrhage of any consequence, the subclavian artery was tied as a matter of safety. Dr. Cooper, of San Francisco, attended a boy seven years old, whose arm and two-thirds of the scapula had been severed by machinery, with little bleeding. The remainder of the bone was removed along with the outer third of the clavicle, followed by rapid recovery. In the three other cases, reported, respectively, by King, Cartwright, and Lowe, there was nothing unusual in the symptoms, and all the patients got well without any untoward occurrence.

The shock in nearly all the cases here detailed was very trifling; and secondary hemorrhage does not seem to have occurred in any, although in several none of the larger vessels were tied. All the patients recovered, most of them very promptly, and without any serious accident.

Paralysis of the muscles of the shoulder, but more particularly of the deltoid, the result generally of external injury, as a blow or fall upon the part, is sometimes met with, and often proves exceedingly obstinate, if not irremediable. Although the affection is ordinarily occasioned by direct injury, cases occur in which it is produced indirectly, through force applied to the elbow or hand. A considerable number of cases have fallen under my observation in which the attack was apparently due to the effects of cold.

The immediate cause of the paralysis appears to be the contusion, compression, or laceration, or these different lesions combined, of the nerves of the affected muscles, and, doubtless, also of the fibres of the muscles themselves. However this may be, the muscles, the natural stimulus of which is thus cut off, soon fall into a state of atrophy, becoming thin and flabby, and partially, if not completely, powerless. By degrees, the morbid influence extends to the shoulder-joint, causing inflammation of the synovial membrane, followed by morbid adhesions between the contiguous surfaces, and eventually, in many instances, by complete ankylosis. The sensibility of the part is often, although not always necessarily, much impaired, and the patient usually experiences fixed or darting pains, resembling those of rheumatism. The paralysis may be limited to the deltoid, or it may affect, either simultaneously or successively, the other muscles of the shoulder, as well as some of those of the arm and forearm, followed by a cold and withered condition of the entire limb. The general health is usually more or less impaired.

The prognosis is variable. In the milder cases, the parts, under judicious management, commonly recover in from three to eight weeks, whereas, in the more severe ones, very little benefit is to be expected from therapeutic measures of any kind.

The treatment of paralysis of the muscles of the shoulder must, in the first instance, be conducted upon strictly antiphlogistic principles; by rest, leeches, and soothing applications, as weak solutions of lead and opium, spirituous lotions, or arnica and laudanum, with a view of subduing the inflammation which must necessarily follow whenever the disease is of traumatic origin. Subsequently our main reliance must be upon hot and cold douches, frictions, stimulating liniments, passive motion of the shoulder-joint, shampooing of the muscles, and electricity. The general health must not be neglected. In most cases, the patient will be greatly benefited by a course of tonics, alterants, change of air, and sea-bathing. In obstinate cases I have sometimes derived marked relief from the repeated application of a blister.

Ankylosis of the shoulder-joint may be caused by injury, or by want of use from paralysis of its muscles, eventuating in effusion of plastic matter. Such cases generally admit of cure, simply by breaking up the morbid adhesions under chloro-

form, and then instituting a regular system of passive motion, aided by the use of the douche, sorbefacient liniments, and dry friction. When the ankylosis is osseous and not too extensive or old, an effort may be made to destroy the connections with the perforator employed subcutaneously; or, this failing, resection may be performed.

Injury and rheumatism of the shoulder-joint are sometimes followed by contraction of the soft parts in its vicinity, seriously interfering with the restoration of its functions. Passive motion will do much for such cases, and the knife can only be required when there is marked shortening of the pectoral muscle, pinioning the arm to the side. In making the section of the muscle, regard must be had to the safety of the axillary vessels and nerves.

In consequence of burns and scalds giving rise to *vicious cicatrices*, the arm is sometimes pinioned to the side of the chest, thus restricting the movements of the shoulder-joint, and rendering the limb in great degree useless. Unless the attachments are very broad and extensive, a very simple operation, consisting in the division of the fibrous or cutaneous bands, will generally suffice to afford relief, especially if care be taken during the healing process to keep the arm away from the trunk. Occasionally it will be found necessary to aid the cure by the division of some of the fibres of the pectoral muscle.

A remarkable case of injury of the superior extremity caused by a burn, and followed by sloughing of the shoulder, including the whole scapula and clavicle, was communicated to me, in 1865, by Dr. W. S. Hitch, of Delaware. The patient, a female, twenty-three years of age, in an epileptic fit, fell into the fire, where she remained until she awoke from the attack. The arm and shoulder, together with a portion of the breast, were found, soon after, to be completely charred and insensible. Mortification rapidly set in, a line of demarcation formed, and precisely four weeks from the time of the accident, the parts were detached by nature's efforts. The granulating process proceeded kindly, and the stump finally completely cicatrized.

Various kinds of *tumors*, benign and malignant, solid and fluid, are liable to form upon or around the shoulder, commencing either in the soft structures, in the joint, or in the bones, especially the scapula and humerus. Of the benign growths liable to appear here the most common are the fatty, fibroid, and enchondromatous, all of which are capable of attaining a great bulk; they are distinguished chiefly by the tardiness of their development, and by the fact that they generally occasion no other inconvenience than what results from their weight and size. Erectile tumors

are always easily recognized by their history, color, and consistence. They are situated either in the skin, or skin and cellular tissue, and are, for the most part, of a purely venous structure, although sometimes they are decidedly aneurismal.

The annexed sketch, fig. 738, represents an enormous enchondroma of the left shoulder of an elderly woman, measuring twenty-seven inches in length, and estimated to weigh upwards of fifty pounds. The drawing was sent to me by Dr. R. H. Brown, of the army. The growth had begun six years previously in consequence of a severe blow.

In a case of cartilaginous tumor under my observation in 1864, in a man twenty-six years old, the mass occupied the right shoulder, and involved the whole scapula and nearly the upper half of the humerus, along with the outer extremity of the clavicle. It was of very irregular shape, and almost of bony hardness, measuring



Enchondroma of the Shoulder and Arm.

forty-five inches in circumference at its base, and weighing, as was ascertained by Dr. Bigelow after death, thirty-one pounds. It had been first noticed about six years previously, as a small tumor upon the back of the scapula. The man's general health had remained excellent until within a short time of his death. The size of the tumor had more than doubled itself during the last twelve months of his life.

This tumor might, doubtless, have been removed before it had acquired its great bulk. Dr. J. B. S. Jackson, who dissected the man after death, states that it was

easily separated from the walls of the chest, and that the subclavian vessels and nerves ran along its surface, but were not imbedded in it. A section of the mass, kindly sent to me by Dr. J. C. Warren, of Boston, exhibited all the characteristic features of the enchondromatous formation.

A very curious tumor sometimes forms upon the shoulder in consequence of a hypertrophied condition of the skin and subcutaneous cellular tissue, strongly resembling *elephantiasis* of the scrotum and other parts of the body. A remarkable case of this kind has been reported by Nélaton in a man twenty-eight years of age. It had taken its rise sixteen years previously by a narrow pedicle in the neck on a line with the fifth cervical vertebra, and at the time of its removal formed an immense fold covering in the posterior part of the trunk, along with the right shoulder and arm, as far down as the sacrum. Its weight was twenty-five pounds. Large veins traversed it in every direction, and all the smaller vessels were excessively increased in size. The tumor, which had much increased in bulk within the last eighteen months, was transfixed with numerous stout ligatures, tied so firmly as effectually to strangle the whole mass. The growth was then cut off, the pedicle alone being left to slough. Violent erysipelas arose soon after the operation, followed by death on the fifth day.

Of malignant tumors almost the only one liable to occur here is the *encephaloid*, which may take its rise either in the cellular tissue, or, as is more commonly the case, in the scapula, humerus, or clavicle. It is characterized by the rapidity of its growth, its soft, semielastic consistence, its deceptive sense of fluctuation, and its great bulk. Enlargement of the subcutaneous veins is generally a prominent phenomenon.

In regard to the treatment of these tumors no definite rules can be laid down. When situated superficially, they should be extirpated in the usual manner; if, on the contrary, they involve the osseous structure, excision or amputation will be required, and the sooner the operation is performed the better for the patient and the surgeon.

4. AFFECTIONS OF THE AXILLA.

The axilla is liable to wounds, inflammation, abscess, tuberculosis of the lymphatic glands, encysted tumors, and malignant disease, especially *encephaloid* and *scirrhus*. Aneurism may also occur here, but as this disease is described elsewhere, it is not necessary to repeat what was then said.

Wounds in this situation acquire their chief importance from their involvement of the axillary vessels and nerves. They may be of various kinds, as incised, lacerated, punctured, or gunshot, and must be treated upon the same general principles as similar injuries in other regions. Bleeding from the axillary artery must be checked with the ligature, applied both to the cardiac and distal side of the vessel, thoroughly exposed for the purpose, the wound serving as a guide to the knife. A good deal of embarrassment frequently attends the operation on account of the infiltrated and discolored condition of the areolar tissue, which, from its great laxity, admits of the ready diffusion of the blood. The subclavian artery should never be tied for such an accident.

It is not often that the division of the axillary artery is followed by gangrene of the hand, but such an occurrence will be very likely to ensue when the lesion coexists with a wound of the axillary vein, or of some of the principal nerves of the limb. In the latter event, indeed, mortification may arise without any injury whatever of the vessels.

Wounds of the axilla, from their peculiar valve-like shape, and the movements of the shoulder, are occasionally followed by *emphysema*, even when there is no injury of the lung. As such a phenomenon might cause great alarm in the mind of an ignorant surgeon, it deserves to be remembered as one of the possible contingencies of a traumatic lesion in this situation.

The cicatrization of wounds of the axilla will be materially expedited, if, after their edges have been properly drawn together, the arm be carefully fastened to the side, so as to insure perfect quietude to the parts.

Inflammation, of a common, phlegmonous, or erysipelatous character, not unfrequently makes its appearance in the axilla, and is liable to cause great suffering, besides occasionally terminating in extensive abscesses. Terrible attacks of inflammation of the lymphatic glands, attended with fatal results, sometimes follow the

absorption of poison, such, for example, as that received in dissecting. The virus appears to be arrested in these bodies, which, in consequence, soon become swollen, tender, and exquisitely painful, the tumefaction generally rapidly spreading over the whole limb, and occasionally even over the corresponding side of the trunk.

Acute abscesses of the axilla are sufficiently common. The matter may be confined entirely to the areolar tissue, or it may at the same time be disseminated through the lymphatic glands. When the suppuration is at all profuse, the fluid may burrow freely among the surrounding parts, passing, perhaps, forwards beneath the pectoral muscles, backwards under the scapula, up into the neck, or even into the anterior mediastinum, although such an event must necessarily be very uncommon, and should always be guarded against by a timely outlet for the pent-up fluid. In performing the operation, the surgeon must not lose sight of the close proximity of the axillary vessels, otherwise he might produce a frightful, if not fatal, hemorrhage. The most prudent plan will be, unless the matter is very superficial, first to incise the skin, and then to divide the tissues, layer after layer, with the knife, guided by the grooved director.

Chronic abscesses of the axilla are by no means uncommon, especially in young, strumous subjects, the matter, which is often very abundant, evidently forming in connection with diseased lymphatic glands. The progress of the swelling is generally very slow, and the phenomena of ordinary inflammation are frequently entirely absent, although occasionally the skin over the affected glands is abnormally hot, red, tender, and painful. The pus is always characteristic. The treatment must be by free incision, followed by sorbefacient applications, and by a course of alteratives, or alteratives and tonics.

Tuberculosis of the lymphatic glands of the axilla is sometimes met with, generally as a chronic enlargement, these bodies being aggregated together in such a manner as to form a hard, circumscribed, nodulated mass, easily distinguishable by its history, its consistence, the absence of pain, and its gradual tendency to suppuration. It is most commonly found in young subjects, in association with tuberculosis of other parts of the body, particularly of the lymphatic glands of the neck and supra-clavicular region. The disease is tardy in its progress, but the resulting tumor may, in time, acquire a very large bulk. The general health, at first unimpaired, ultimately suffers, and the patient may finally fall into a state of marasmus, although, in most cases, he will be likely to make a good recovery. The most common cause of the disease is cold acting upon a debilitated constitution. Occasionally it is dependent upon caries of the ribs or disorder of the mammary gland.

The treatment is conducted upon general antistrumous principles, iodine and bichloride of mercury constituting the more important internal remedies; leeches, blisters, and sorbefacients the most reliable topical ones. If matter form, it should be promptly evacuated, the disorganized glands being destroyed with escharotics. If the disease prove intractable, the altered mass should be extirpated.

A *cystic tumor* occasionally occurs in the axilla; generally as a congenital affection, of a rounded, semiglobular form, soft, fluctuating, free from pain, and filled with a watery, coagulable fluid. An interesting case of this kind, in a stout and otherwise healthy child, six months of age, was sent to the College Clinic by Dr. Conry, of Manayunk. The sac, which contained about four ounces of limpid serum, was laid freely open, and its inner surface thoroughly mopped with a weak solution of iodine. The operation was followed by a speedy cure.

A remarkable case of *fatty tumor* of the axilla, weighing twenty-one pounds, in a man fifty-seven years of age, has been reported by Dr. A. H. Scott, of Dover, Arkansas. It reached three inches below the anterior superior spinous process of the ilium, was of a pyriform shape, and measured forty-five inches in circumference at its base. Removal was readily effected by enucleation.

Sarcomatous tumors are liable to arise in the axilla, and are usually characterized by rapid development, commencing either in the lymphatic glands or in the connective cellular tissue, and capable, if let alone, of attaining a great bulk. The distinction between them and encephaloid is difficult, if not impossible, so closely do they resemble each other in their general external features.

Malignant growths of the axilla, as primary affections, are most common in elderly subjects, and the form in which they usually appear is that of *encephaloid*, commencing as a small, nodulated tumor, which often, in the course of a few months, acquires an immense bulk. The mass feels hard, or hard at one place and soft at another,

and, although movable at first, soon becomes firmly fixed in its position, filling up completely the hollow between the arm and the chest. The subcutaneous veins gradually increase in size, and the morbid mass at length breaks and gives way, forming a fungous, bleeding ulcer, the seat of a more or less copious, fetid discharge. The general health, in the mean time, is greatly impaired, the corresponding limb is stiff and œdematous, and the system is racked with pain. Death usually occurs in from twelve to eighteen months. Mr. Butcher, of Dublin, has described two cases of enormous encephaloid tumors of the axilla, in both of which the pleural cavity on the affected side contained at least a gallon of watery fluid.

Scirrhus of the axilla is generally the result of secondary involvement in connection with carcinoma of the breast; as an independent disease, it is very uncommon. The tumor, which sometimes acquires a large bulk, as in fig. 739, from Erichsen, usually extends further down the chest than in encephaloid, and is always the seat of sharp, lancinating pain, which, together with its history, form, and consistence, and the absence of enlargement of the subcutaneous veins, serves to distinguish it from soft carcinoma.

The only remedy for these diseases is extirpation. The operation, however, besides affording the merest temporary relief, is one of great delicacy, from the fact that the axillary vessels and nerves are often involved in the morbid mass. In performing operations upon the axillary region, special care must be taken not to wound the axillary vein, inasmuch as such an accident might be followed by fatal consequences from the introduction of air, as happened to Dupuytren, Wattman, John C. Warren, Clement, and others.

Great uncertainty often prevails regarding the *diagnosis* of the affections in this situation. Thus, for example, surgeons have occasionally mistaken an aneurism of the axillary artery for an abscess. Ferrand, Desault, Dupuytren, and Syme, each committed an error of this kind, followed in all, except the latter, by death. On the other hand, a solid tumor may be confounded with an aneurism. Pelletan and Nicoll each ligated the subclavian artery in a case of encephaloid under the supposition that the malady was aneurism. Both patients perished. Such blunders—for this is the mildest term that can be applied to them—should serve to put surgeons upon their guard in reference to the diagnosis of diseases of the axillary region.

Fig. 739.



Scirrhus of the Axilla.

5 BANDAGES FOR THE SUPERIOR EXTREMITY.

Bandaging of the *fingers* is a very nice operation; it is particularly called for in inflammation after fractures of the radius and ulna, and in cases of burns and scalds, with a view to the prevention of adhesions. The roller should be from three-quarters of an inch to an inch in width, and should be carried up, by circular and reversed turns, as far as the root of each member, when the extremity should be stretched across the back of the hand, which, when all the fingers are enveloped, should be surrounded with a broad bandage, extending from the knuckles a short distance beyond the wrist, as exhibited in fig. 740.

For retaining dressings upon the *hand*, the bandage represented in fig. 741 is usually employed. It consists of a roller, an inch in width, and several yards in length, carried, first, around the wrist, and afterwards across the carpus, in front and behind, in such a manner as to embrace the root of each finger.

Fig. 740.



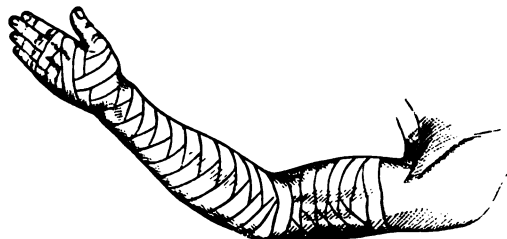
Fig. 741.



Bandages for the Hand and Fingers.

The most suitable bandage for the *forearm and arm* is the ordinary roller, fig. 742. The application, commenced at the fingers, is gradually continued up the limb

Fig. 742.



Roller for the Superior Extremity.

as far as the elbow, and thence as high up as the axilla, where the end is fastened with a pin. Sometimes, as when it is desired to secure the arm to the side, the bandage may be carried horizontally around the trunk. The hollow of the hand may, if necessary, be filled up with cotton, lint, or old muslin. Great care must be taken in carrying the bandage around the elbow, otherwise it will be apt to lose its hold or to produce undue compression.

The usual length of the roller for the upper extremity is from six to eight yards, its width being about two inches and a quarter. In cases of fractures and other injuries, likely to be followed by severe swelling of the hand, the thumb and fingers should be put up in separate bandages.

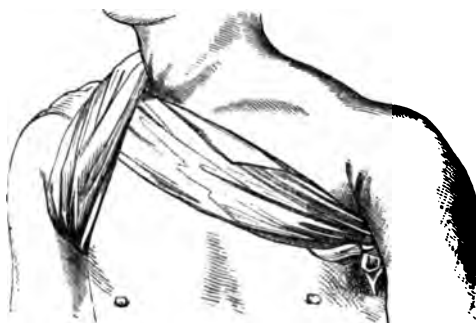
For confining dressings in the treatment of wounds, abscesses, and other affections of the

Fig. 744.



Spica for the Shoulder and the Upper Part of the Arm.

Fig. 743.



Bandage for the Axilla.

axilla, the most simple and efficient contrivance that can be used is a large handkerchief, folded cornerwise, the centre being placed under the arm, and the ends, crossed over the shoulder, carried around the chest, and tied under the opposite axilla, as illustrated in fig. 743.

The *spica* bandage for the shoulder and the upper part of the arm, represented in fig. 744, consists of a roller from eight to ten yards in length by two inches and a half in width, with compresses for the axilla of the affected side. Leaving about two feet and a half of the end of the bandage pendent at the posterior part of the arm, the application is commenced by several spiral and reversed turns around the limb, passing from its outer towards its inner surface. The bandage is then carried up over the outer aspect of the shoulder, obliquely across the anterior part of the chest, to the axilla of the sound side, and thence across the back to the affected shoulder. In this manner one turn after another is made, each succeeding one partially overlapping the preceding one, until the roller is consumed, when the initial extremity at the back part of the limb is brought around under the axilla, and thence over the front of the shoulder and around the back of the neck to the sound side, where it is secured by a pin.

SECT. II.—INFERIOR EXTREMITY.

1. AFFECTIONS OF THE FOOT AND TOES.

The foot and toes, like the hand and fingers, are liable to various affections, either congenital or acquired. Among the former are supernumerary, webbed, and hypertrophied toes, flat-foot, and club-foot; among the latter, corns, bunions, *podelkoma*, *pododynia*, and certain diseases of the toes.

CONGENITAL AND OTHER DEFORMITIES OF THE TOES.

Congenital absence of the toes is a very rare occurrence; *supernumerary toes*, on the contrary, are not very uncommon, the additional member being usually connected with the large toe, which it closely resembles in shape, although it does not equal it in bulk. The anomaly sometimes exists on both feet, and cases are met with where it is associated with an additional thumb. The supernumerary member is not only unseemly, but, by increasing the width of the foot, may seriously interfere with the patient's comfort and convenience. Hence, it should always be removed soon after birth. The operation is very simple, the only care required being to take away the whole of the anomalous toe, and to leave a sufficient amount of integument to afford a good covering for the exposed surface. The connection is sometimes simply by a cutaneous pedicle instead of by a distinct articulation.

A *webbed* condition of the toes is uncommon, and rarely affects more than two or three of these pieces. I have seen only two cases in which all the toes were thus united. The remedy is the same as for webbed fingers.

Hypertrophy of the toes is still more uncommon than hypertrophy of the fingers. It is usually congenital, and the affected parts may acquire a very large bulk, thus greatly interfering with the comfort and convenience of the foot. The proper remedy is removal of the offending structures, as it would be worse than useless to waste time upon compression and other sorbefacient means.

The hypertrophy may be limited to the toes, or, instead of this, it may involve also the foot, leg, and thigh, as in a remarkable case at the Philadelphia Hospital, in a little girl two years and a half old. The enlargement was, as usual, congenital, and extended over the entire left extremity, with the exception of the heel and the fourth and fifth toes, which were little, if at all, affected. The circumference of the limb was nearly twice that of the sound one. The length of the foot and great toe was six inches and a half; the thigh and leg were notably elongated; and the soft parts were of a dense, fibroid consistence. The chief mass of the limb seemed to consist of adipose matter strongly intermixed with fibroid substance. The microscope revealed the existence of numerous fat cells. The child had for some time past labored under tubercular disease of the lungs and a scaly, syphilitic eruption of the skin.

Deformity of the toes occasionally arises from the effects of rheumatism, from paralysis, or from the wearing of a tight shoe, causing them to project in an un-

seemly and inconvenient manner, either above or below the natural level, as in fig. 745, or producing an incurvated, claw-like appearance. The immediate cause of the distortion is a contraction of the tendons of the flexor muscles, which should accordingly be divided, as they pass beneath the first phalanx, by subcutaneous section, the faulty toes being afterwards treated in the extended posture by splint and

Fig. 745.



Deformity of the Second Toe.

Fig. 746.



Deformity of the Great Toe from Inflammation of the Metatarso-phalangeal Joint.

bandage, until they are completely straight. When the great toe is mainly involved, as generally happens when the affection is induced by paralysis, or by inflammation of the metatarso-phalangeal joint, as in fig. 746, it may be necessary to divide the long flexor in the sole of the foot; but, in doing this, proper care must be taken to keep the knife close to the affected tendon, made previously as tense as possible, otherwise the internal plantar artery might suffer.

WOUNDS OF THE FEET AND TOES.

Wounds of these parts require the same treatment as similar lesions in other regions. The hemorrhage which complicates them is often profuse, and not always easily arrested, especially when it proceeds from the plantar arteries, owing to the great depth at which they are situated, and the confused condition of the tissues, if some time has elapsed since the occurrence of the injury. Acupressure with long needles, deeply inserted, frequently answers better here than the ligature. When the bleeding cannot be controlled in this way the proper plan is to enlarge the wound, and to tie the vessel at both ends. For further remarks upon this subject, the reader is referred to the chapter on the arteries in the first volume.

Punctured, contused, and lacerated wounds of the feet are extremely liable to be followed by erysipelas, abscesses, and even tetanus, especially in persons of a nervous, irritable temperament, and they should, therefore, always be watched with the greatest care until the danger is fairly passed. Free incisions are often required to relieve pain and tension, as well as to evacuate the pent-up fluids; and anodynes, in large and sustained doses, can seldom be dispensed with, if the suffering be at all severe. Among the best local applications are strong solutions of acetate of lead and opium. Leeches, blisters, and iodine are also valuable agents.

Foreign bodies, as needles, tacks, splinters of wood, chicken bones, and pieces of glass, are very liable to lodge in the sole of the foot, where, if they are not speedily removed, their presence may occasion the most disastrous consequences, as tetanus, erysipelas, and abscesses. Hence no time should be lost in getting rid of them, and for this purpose large incisions are often required, the knife being guided by the puncture left by the foreign substance, or by the sensation which the substance imparts to the finger.

The toes and feet are sometimes badly contused; and cases occur in which the injury is attended with more or less extravasation of blood, followed by severe pain and tenderness in the parts. The most suitable applications are lotions of lead, arnica, and laudanum. If the blood is slow in disappearing, or if it be productive of severe distress, by the pressure which it exerts upon the surrounding structures, it should be evacuated through a small puncture.

The toes often suffer severely by being struck forcibly against a hard, projecting

body, as a stone, step, or piece of timber. The concussion thus occasioned not only causes violent pain, but is very liable to be followed by stiffness of the joints, the effects of which may not pass off for many months, if ever. Such cases should always engage the serious consideration of the practitioner.

INFLAMMATION.

Inflammation of the foot and toes, especially of the former, is extremely prone to assume an erysipelatous character, particularly when caused by punctured, contused, or lacerated wounds. The disease often spreads to a great depth, causing severe swelling, with intense pain and excessive constitutional disturbance. If matter form, it will be very liable to burrow, owing to the resistance offered by the plantar aponeurosis, thus seriously complicating the case, and augmenting the suffering. When the pus is pent up for any length of time, there will be danger of involvement of the bones, leading to caries and necrosis, especially in subjects of a strumous habit of body. The toes sometimes suffer from a form of inflammation, closely assimilating itself to paronychia; deep-seated, extremely painful, and of a spreading tendency, with an erysipelatous condition of the skin.

The great points in the treatment of inflammation of these structures, apart from the ordinary measures, are to relieve tension and to afford early vent to effused fluids, particularly to pus, that no undue ravages may be committed by burrowing. These indications are fulfilled by free and timely incisions, care being taken that no injury be inflicted upon the plantar arteries. Leeches are generally of immense service in these inflammations, and the same is true of lead and opium, especially in the earlier stages of the disease.

CORNS.

Corns consist in an indurated and hypertrophied condition of the cuticle, caused by inflammatory irritation of the superficial portion of the dermis, and the consequent effusion of lymph. They affect different parts of the toes and feet, and are generally produced by wearing tight shoes and boots, whereby these organs are habitually compressed and even forced out of their normal position. A short, tight stocking occasionally produces a similar result. Corns are very variable in regard to their size, form, and consistence. They are usually distinguished into hard and soft.

Hard corns are dry, scaly, insensible callosities, occurring mostly on the dorsal surface of the toes, opposite the middle joints. All these structures are occasionally affected, but the great and little toes suffer much more frequently than any of the rest. These bodies are met with also in the sole of the foot, in the hollow or arch, and on the under part of the heel. Occasionally a very hard corn is found under the nail of the big toe, or between the nail and the fleshy part of the toe.

A hard corn, when fully developed, is lamellated, firmer at the centre than at the periphery, and furnished with a kind of nucleus, of a whitish, horny appearance, not unlike the eye of a fowl. A small, but distinct burse, containing a minute quantity of serous fluid, and sometimes a drop of blood, is almost always interposed between it and the dermis, the papillæ of which are depressed, diminished in number, or entirely destroyed. These appearances are well shown in the adjoining sketch, fig. 747, from Follin. The hard corn frequently consists of three or four layers; it is commonly of a circular shape, is either fixed or movable, and varies in size from the head of a pin to that of a dime. In many cases it has a kind of radiated root.

The hard corn, from a continuance of the pressure by which it is produced, becomes gradually a source of pain and tenderness, which are much increased by exercise, and are often accompanied by heat and swelling of the whole foot. In time the burse under the horny cuticle inflames, and pours out an unusual quantity of fluid, which distends the sac, and thus greatly aggravates the suffering. When matter forms, the pain becomes excruciating, the slightest touch is intolerable, and the patient is unable to use the limb. In such cases the lymphatic vessels are sometimes inflamed as high up as the groin.

Fig. 747.



Structure of a Corn.

Soft corns are always situated between the toes, usually opposite a joint or at their angle of union, and derive their characteristic features from being in a constant state of moisture, from the perspiration which collects between these parts; they are usually superficial, and are produced by wearing very narrow-soled shoes, by which the toes are habitually squeezed together, bent at their articulations, or forced over or under each other. For this reason ladies are more subject to this variety of corn than men or the poorer classes of females. The soft corn is of a circular or oval figure, of a whitish, yellowish, or grayish color, with a radiated or horny-looking nucleus, and is seldom larger than a split-pea or half a dime. Occasionally it is broad, oblong, flat, and of a dark color, from the presence of extravasated blood. In some instances, especially in old people and in cases of long standing, the corn is very hard at the centre, has a small synovial burse, and consists of several distinct layers. From being constantly compressed, it is very painful, and remarkably prone to inflammation, suppuration, and even ulceration.

The *treatment* of corns consists in scraping away the thickened cuticle, and lightly touching them with nitrate of silver, or tincture of iodine, repeated occasionally until the cure is completed. This may be greatly expedited by washing the feet night and morning with cold water and soap, and afterwards rubbing them well with a soft, dry towel. The shoe, which should have a low, broad heel, should be accurately adapted to the shape of the limb, and all undue pressure carefully avoided, even from the seam of the stocking. When the toes are much deformed, or incurvated, they are to be kept apart by pledgets of lint, a piece of soft sponge, or strips of adhesive plaster passed from one to the other. When this cannot be done from their fixed position, amputation may become necessary. In some instances it is useful to make the patient wear a stocking constructed on the principle of a glove, each of these organs having a separate stall. A shoe made of buckskin or cloth sometimes affords great relief.

When corns are very tender, they should be frequently scraped with a blunt knife, and kept constantly covered with a piece of soap plaster, or a bit of linen spread with simple cerate to prevent them from becoming hard and dry. In some instances the pressure may be warded off by letting the corn project through a hole in the plaster, which ought then to be very thick, or consist of several layers. When the corn is seated in the sole of the foot, and this treatment is employed, it must be first covered with a piece of adhesive plaster, otherwise the weight of the body will cause the flesh to project into the opening, and thus produce severe pain in walking. Occasionally it is necessary to cut a hole in the boot or shoe, or to wear a felt sole with a hole in it, to protect the corn from pressure and friction. All these means, however, are merely palliative, and, when they fail, nothing short of complete eradication will answer. The operation, which is seldom painful, is performed with a small narrow-pointed scalpel and pair of forceps, care being taken not to injure the sensitive skin beneath, and to soften the corn by previous immersion in warm water. When an abscess forms, it should be opened as speedily as possible, after which the offending part may be removed, or this may be postponed to another day. Sometimes the matter escapes by ulceration, leaving a fistulous sore with thick, irregular edges, and constantly bathed with a thin, ichorous fluid. In such a case nitrate of silver constitutes the best remedy.

When corns are inflamed, they cannot be treated with too much care, since, if neglected, they may give rise to serious mischief. The foot should be kept perfectly at rest, and it may even be necessary to resort to leeches and medicated fomentations. The knife should be used most cautiously. Several instances have fallen under my observation in which the cutting of an inflamed corn was followed by violent erysipelas and mortification; and numerous cases are recorded in which these diseases, thus occasioned, have caused death.

BUNIONS.

A bunion is a corn on a large scale, caused in a similar manner, having a similar structure, and requiring a similar treatment. It consists in a thickening and induration of the common integument over the first metatarso-phalangeal joint, accompanied by malposition of the great toe, which is usually forced inwards, either against, over, or under the adjoining one, thus occasioning a sharp, angular projection on the outside of the articulation. These appearances are well shown in fig.

748, from a female patient. The whole difficulty is originally dependent upon the wearing of a short, narrow-soled, high-heeled boot, by which the whole weight of the body is thrown upon the anterior part of the foot in progression. A similar tumor sometimes forms over the first joint of the little toe. Hereditary malformation, preternatural laxity of the ligaments, and a gouty or rheumatic state of the system, may be mentioned as so many predisposing causes of the complaint.

The cuticle, when the disease is somewhat advanced, is thick, scaly, or lamellated, hard, brawny, and, at times, studded with superficial corns; the subjacent bursa, which is often of large size, and occasionally communicates with the articular capsule, contains a considerable quantity of synovia; and the corresponding joint of the toe is always chronically inflamed and hypertrophied, if not partially ankylosed. Exercise is painful, and never fails to aggravate the disorder, not unfrequently occasioning erysipelas of the foot, and abscess in the sac of the bunion.

In the worst forms of the disease, a painful, intractable ulcer sometimes forms, and thus greatly increases the local distress. Mr. Oliver Chalk has recorded a remarkable case of bunion in which the ulcer, after having continued for a long time, finally degenerated into epithelial carcinoma.

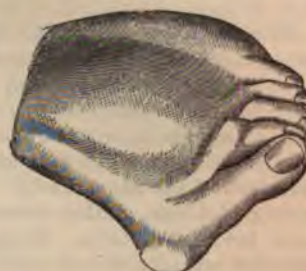
The treatment is palliative and radical. The first thing is to procure a proper shoe, in order to diffuse the pressure over the foot, instead of concentrating it upon the toes. Pain, tenderness, and inflammation are best relieved by rest and elevation, along with leeching, blistering, and cold water, medicated with laudanum and acetate of lead. If matter form, an early and free incision is made down to the bones.

The malposition of the toe may generally be easily rectified, in the slighter cases, by strapping it, from time to time, to the anterior extremity of a trough of sole leather, carefully moulded to the inner margin of the foot, and laced to the instep and heel by appropriate bands. By this arrangement the metatarsus is made to serve as a fulcrum keeping in check the action of the adhesive plaster by which the toe is gradually reduced to its natural situation. When the deformity is more considerable, recourse may be had to the apparatus of Mr. Bigg, represented in fig. 749. It consists simply of a delicate lever of steel, with an oval ring in the centre, and attached by a laced band to the instep. At the anterior and posterior margins of the ring is an ordinary hinge-joint, allowing the articulation to move freely in the natural plane, but calculated to oppose any lateral tendency. The toe is secured to the extremity of the apparatus by a piece of webbing. The patient will generally be able to wear a shoe without any difficulty.

A radical cure may be effected by excision of the sac, but, unless the part and system have been well prepared, the operation may prove dangerous from its liability to be followed by erysipelas. A much safer plan is to divide the sac subcutaneously with a delicate tenotome, cutting it up into numerous fragments, and then pencilling the surface of the swelling several times a day with tincture of iodine. I have practised this method in numerous cases with highly gratifying results. Amputation through the metatarsal bone may become necessary when the parts are hopelessly crippled, and the seat of constant suffering.

The subcutaneous bursae, naturally existing upon the dorsal surface of the joints of the toes, are liable to suffer from inflammation, occasioned by external injury, by the pressure of a tight shoe, or by a rheumatic, gouty, or syphilitic state of the system. The swelling is circumscribed, discolored, hot, tender, and painful. Suppuration may take place, and then the entire toe may become seriously involved in the morbid action, especially if it assumes an erysipelatous character. The treatment is by rest, leeches, saturnine lotions, and tincture of iodine, with free incisions if matter form.

Fig. 748



Bunion.

Fig. 749.



Apparatus for the Treatment of Bunion.

INVERSION OF THE NAIL OF THE GREAT TOE.

The big toe is subject to the inversion of its nail, consisting, as the name implies, in an ingrowing of its edges into the common integument. The affection is productive of severe suffering, and is, therefore, as well as on account of the frequency of its occurrence, deserving of particular attention. It is not peculiar to the big toe nail, although it is most common here, and it is here, also, that it has been best studied. It is most frequent in young adults, and occasionally exists in several members of the same family. Several cases have come under my observation in very young children, under circumstances which induced me to believe that it might have been hereditary. Thus, I know two instances where a mother and two of her children are all afflicted with the disease.

The affection consists essentially in a vicious formation of the nail, in consequence of which its edges become incurvated, and pushed down into the skin at the margin of the toe, which thus overlaps them. This often happens with the hardest as well as with the softest nail. The incurvation generally exists on both sides, although rarely in an equal degree, and we sometimes meet with cases where both the big toes are involved. When the affection is fully developed, the edge of the nail dips into the flesh almost vertically, leaving a well-marked gutter upon the removal of the offending part. Long, however, before it has attained this height, it becomes a source of severe suffering, on account of the pressure which it exerts upon the soft structures at the side of the toe, which at first inflame and swell, and afterwards ulcerate, the sore discharging a foul, fetid fluid, and being usually covered with tender, fungous granulations. In some cases, the inflammation involves nearly the whole toe, which is then proportionately painful, and thus greatly augments the distress; so that, at length, the patient is in constant misery, and hardly able to wear a shoe or take any exercise. The habitual use of a tight, narrow shoe, causing severe lateral pressure, no doubt often contributes to the production of this affection, but most commonly it arises from the vicious manner in which the nail is cut down at the edges, thereby allowing the thickened and indurated integument to rise above the level of the nail, which always grows more slowly than the other structures, in which, consequently, it is ultimately buried. Once formed, it is extremely difficult to get rid of it. Great convexity of the nail no doubt acts as a powerful predisponent.

Various methods of treatment have been suggested for the cure of this affection, most of which can hardly be regarded even as palliatives. Paring the inverted portion of the nail occasionally with a sharp knife, and removing the callous skin

by its side, will always afford marked relief, and may, if steadily persisted in, sometimes eradicate the evil, but, in general, it will soon return, and ultimately call for a more decisive procedure. Scraping the back of the nail, so much lauded by some surgeons, is commonly useless, as it is hardly productive even of transient comfort. Dr. Robert Campbell, of Georgia, recommends systematic compression with a small compress and roller, but the operation, without being by any means free from pain, is troublesome and tedious, from six to eight weeks being required to effect a cure, and even then it is seldom, if ever, permanent. When the affection is fully formed, and the patient's time is valuable, the best plan is at once to excise the offending portion of the nail, chloroform being given to prevent suffering, which will otherwise be excessive. With a stout, narrow, and very sharp scalpel, the nail is divided through its whole length, as seen in fig. 750, down almost to the bone, on a line with the incurvated edge, which is then rapidly detached, root and all being embraced in the dissection. Very little bleeding ordinarily attends the operation, which is over in a few seconds. Warm water-dressing, with acetate of lead and opium, is applied, and the foot is kept at rest until the wound is measurably healed.



Excision of Inverted Toe-nail.

I generally excise both margins at the same time. By this procedure, a large portion of the nail is left for the protection of the toe, and a radical cure is effected. I have repeatedly accomplished the same object simply by

the removal of the indurated skin and cellular substance at the margin of the toe, without interfering at all with the affected nail. The incision is directed in such a manner as to leave a sloping surface, which, after the cicatrization is completed, bears pressure well, and is an effectual guarantee against future trouble. Everything else is merely palliative, the patient being at last obliged, perhaps after long suffering, to submit to the knife. The barbarous practice, formerly so fashionable, of removing the entire nail for the relief of this affection cannot be too strongly condemned, as, aside from its cruelty, it often utterly fails, from the distorted condition of the new nail.

EXOSTOSIS OF THE GREAT TOE.

The last phalanx of the great toe, as seen in fig. 751, is sometimes the seat of an exostosis, so large as to cause serious inconvenience and pain in walking. It may appear at various points of the bone, but generally it is seated at its inner margin, partly under the nail, which, in time, it lifts up and partially destroys by ulceration. Its form is spherical or pyramidal, and in size it varies from that of a millet seed to that of a hazelnut, its structure and consistence resembling those of the natural osseous tissue. Arising generally without any assignable cause, its origin is usually ascribed to a blow, or to the pressure of a tight shoe; it is most common in young adults, is slow in its progress, is attended with more or less fetid discharge, and is amenable to excision with a stout knife, aided, if necessary, by the saw and gouge. Amputation of the phalanx is not to be thought of unless the whole bone, nail, and soft parts are involved in destructive ulceration. A marked tendency to recurrence occasionally exists, requiring further interference. For this reason the excision should always be performed with the greatest possible care. An exostosis sometimes forms on the small toes.

Fig. 751.



Exostosis of the Distal Phalanx of the Great Toe.

CLUBFOOT.

Clubfoot consists in a peculiar distortion of the foot, attended with a deviation from its natural direction, and also, generally, with a diminution of its proper length. Presenting itself in various degrees, the deformity to which it gives rise is sometimes so great as to occasion the most disagreeable disfigurement and the most painful inconvenience, rendering the individual an object of constant attention and remark, as well as sadly interfering with progression.

The affection is for the most part congenital. It may, however, be developed after birth, and even at an advanced period of life, from the foot being accidentally placed in a constrained position, and so retained until the soft structures, particularly the muscles and ligaments, are moulded into a new shape, or thoroughly fixed in their new relations. Various mechanical causes may give rise to it, as splints and bandages, by which the parts to which they are applied are injuriously compressed, or forced out of their normal position. Similar effects are produced by convulsions, dentition, nervous irritation, contusions, sprains, fractures, partial luxations, and preternatural laxity of the ligaments. Sometimes the defect is occasioned by the presence of a corn, an ulcer, or some other disease which induces the person to walk on one side of the foot, the tip, or the heel, to ward off pressure from the tender parts. A vicious habit is thus established, which, if continued for any length of time, as it frequently is, inevitably leads to irregular action of the muscles, and to distortion of the bones into which they are inserted.

Etiology.—The etiology of congenital clubfoot has never been satisfactorily explained. The hypothesis of arrested development, so warmly advocated by some modern pathologists, is altogether untenable, being essentially contrary to the facts of the case in every particular. The imperfect growth, if any such really exist, is not congenital, as this doctrine teaches, but acquired, being the result of causes which are brought to bear upon the child during its intra-uterine life, leading to shortening and contraction of certain muscles, and not to the want of development properly so called. It must be acknowledged, however, that instances occasionally do occur, although rarely, which strongly favor the doctrine under consideration. Thus, I have, in my own practice, seen two infants, born at the full term, but who died

immediately after birth, who had each well-marked harelip, cleftpalate, and clubfoot, the result evidently, so far at least as we can judge of such an occurrence, of an arrest of development. Dr. F. H. Getchell, of this city, met with an instance in which this affection was associated with bifid spine, exstrophy of the abdominal viscera, and absence of the anus and genital organs.

Another hypothesis of the formation of clubfoot that has met with considerable notoriety, is that the distortion is caused by the pressure of the uterus upon the feet of the infant during gestation, in consequence of a deficiency of the amniotic fluid. But the question may be asked, if such an effect may be exerted by this organ upon the feet, why should it not be also exerted upon the hands, head, nose, chin, legs, and knees? Such a coincidence, supposing the doctrine to be true, ought to be of constant occurrence, and yet it is so rare that it is probably not noticed once in a hundred cases of the affection. Besides, it remains to be proved that women who bear clubfooted children have always a deficiency of amniotic liquor.

The most plausible view, perhaps, is that the distortion is produced by a defect of nervous influence, leading to a permanent contraction of certain muscles, with a corresponding retraction and incurvation of the bones into which these muscles are inserted. This hypothesis derives corroboration from what occurs in strabismus, in which the straight muscles of the eye frequently almost in an instant, simply from irritation, or an attack of convulsions, lose their parallelism, without the ability afterwards to regain it except by an operation. Here the contraction of the muscles must be the direct result of a lesion of innervation, or of perverted nervous action; for the effect is generally too rapid to justify the conclusion that it can possibly be due to inflammation, which has sometimes been invoked as its exciting cause. How a lesion of the nerves is produced in the fœtus in the womb is of course inexplicable; but that it does occur, in various forms and degrees, is a clearly established fact. It is worthy of remark, in connection with this hypothesis, and as strikingly confirmatory of it, that congenital clubfoot has been repeatedly met with in the embryo as early as the third and fourth months. Moreover, it is not unfrequently associated with imperfect development of the cerebro-spinal axis, or of certain classes of nerves, and with an atrophied and contracted state of the muscles in different portions of the body, especially of the back, shoulder, and hand.

The congenital variety of clubfoot often affects both feet, but rarely in an equal degree. The relative proportion, however, of double to single clubfoot has not been determined; and it is not unlikely that it varies materially in the practice of different surgeons. In my own hands the number of cases of single clubfoot has considerably exceeded—perhaps in the proportion of three to two—the number of double cases. In 167 cases, reported by Dr. Detmold, of New York, the distortion occupied both feet in 93. At the Royal Orthopædic Hospital, London, the two forms are said to occur almost with equal frequency. Thus, of 688 cases, 363 were double, and 326 were single. When the distortion is single, it involves the right foot a little oftener than the left. Both sexes are liable to clubfoot, but males suffer more frequently than females, probably, if I may judge from personal observation, in the proportion nearly of two to one. Some very remarkable cases have been recorded of the occurrence of this distortion in different members of the same family. In one instance, observed by Held, all the children, six in number, were the subjects of congenital clubfoot; and its history would seem to show that the affection was hereditary, inasmuch as one of the parents was laboring under a similar infirmity.

Varieties of Form.—Clubfoot presents itself under several varieties of form, of which there are four principal ones, differing from each other not only in regard to the character of the distortion and the accompanying phenomena, but likewise in relation to the frequency of their occurrence, and the nature of their treatment. These may be respectively denominated the inverted, everted, phalangeal, and calcaneal varieties, each name having reference to the manner in which the limb touches the ground in standing or progression. Thus, in the inverted clubfoot the inner margin of the foot is inclined upwards, while in the everted it is turned downwards; in the phalangeal variety the heel is elevated, and in the calcaneal it is depressed, the toes, in the former case, being, of course, turned down, and up in the latter. Besides these varieties there are several subdivisions, depending upon a combination of two of the principal forms, as, for instance, the inverted and phalangeal, which are extremely common, and the inverted and calcaneal, which are more rare. Of 1218 cases of congenital and noncongenital clubfoot, recorded by Lonsdale, varus

existed in 583, equino-varus in 112, equinus in 226, valgus in 151, calcaneal in 50, equino-valgus in 40, and different compound forms in 56.

The most common form of clubfoot by far is the *inverted*, usually denominated *varus*, figs. 752 and 753, in which the patient walks upon the outer ankle, the great toe being directed inwards and upwards. The muscles of the calf and the adductors of the foot are contracted, and hence there is not only elevation of the heel, but a peculiar inward twist of the foot, analogous to supination of the hand. This alteration occasions the most serious impediment to progression, and when it reaches its highest point imparts a most disagreeable aspect to the affected limb. In the more severe grades of the disorder, the sole of the foot is literally scooped out, as it were, as well as deeply furrowed; the instep, on the contrary, is unusually convex and prominent; the small toes generally present in a vertical position, while the big one, separated from the rest, looks upwards and inwards; the outer margin of the foot, which, in conjunction with the corresponding malleolus, chiefly sustains the weight

Fig. 752.



Fig. 753.



Varus.

of the body, is almost semicircular in its shape, rough, and callous; and the tendo Achillis, forced obliquely towards the inner side of the leg, forms a tense, rigid cord beneath the skin.

When both feet are affected with varus, their points may form an acute angle with the leg; or they may approach so nearly as to touch, and even overlap each other. In the majority of cases the thigh and leg retain their natural conformation, being merely somewhat atrophied; occasionally, however, the knees project slightly inwards or outwards, in consequence of the contraction of the hamstring muscles.

The second variety of this deformity, anciently called *valgus*, fig. 754, may be regarded as the opposite of varus, the patient treading on the internal margin of the foot, while the external is entirely removed from the ground. The sole is directed outwards and slightly backwards, the toes are more or less elevated, and the outer ankle is in a state of semiflexion. The heel is drawn upwards and somewhat outwards, the internal malleolus is uncommonly prominent, the instep is flatter than natural, and the muscles of the calf, together with the abductors of the foot, are permanently contracted. When the disease has attained its highest point, the patient has an unsteady, vacillating gait, from the difficulty which he experiences in preserving his centre of gravity. Valgus is comparatively rare; like the first variety of the

Fig. 754.



Valgus.

distortion, it may affect one or both limbs. It is seldom congenital, but is almost always produced by some local injury, as a sprain, blow, or contusion. The most simple form of the affection constitutes what is called flatfoot.

The phalangeal variety of clubfoot, figs. 755 and 756, the *pes equinus* of the older writers, is caused by a shortening of the gastrocnemial and soleal muscles, aided, in some cases, by the flexor of the toes. It is nearly always, in its uncomplicated forms, a noncongenital affection.

Fig. 755.



Fig. 756.



Equinus.

In this variety of the deformity the individual walks upon the ball of the foot, the toes, or the metatarso-phalangeal articulations, without the heel or any other part of the sole touching the ground. The distance to which the heel is raised ranges, in different cases, from six lines to four or five inches, according to the extent of the contraction upon which the distortion depends. Considerable diversity is observed in regard to the manner in which the person treads on the ground; most commonly the ball of the little toe bears the brunt of the pressure, but in some instances the weight is thrown upon the great toe, or it is diffused over the whole of the forepart of the plantar surface. In the worst grades, the heel is so much elevated that the foot forms nearly a straight line with the leg, the toes are much deformed, and per-

haps retracted, if not doubled under, the instep is unnaturally convex, from the projection of the astragalus, the plantar aponeurosis is greatly contracted, and the skin above the heel is thrown into large, dense wrinkles. Phalangeal clubfoot, without any complication with the other forms of the affection, is exceedingly rare.

Fig. 757.



Calcaneus.

In the fourth variety, the *calcaneal*, fig. 757, the limb rests upon the heel, the toes being drawn upwards towards the anterior surface of the leg, with which they sometimes form an acute angle. The immediate cause of the deformity is a contraction of the anterior tibial muscle and of the extensor of the great toe, assisted occasionally by that of the common extensor of the foot. The tendons of these muscles form an evident protuberance under the skin, where they present the appearance of tense, rigid cords, which powerfully resist the flexion of the limb. The inner margin of the foot, as seen in the cut, is sensibly elevated above the outer, and there is always considerable atrophy of the leg. The distortion,

which is almost constantly congenital, is exceedingly rare. I have seen only a few cases of the noncongenital variety. The most remarkable one was that of a young female, who, in consequence of an ulcer on one of the toes, had got in the habit of walking on the heel, until at length the parts became rigidly fixed in their abnormal position. Occasionally the foot inclines slightly outwards, owing to the inordinate contraction of the common extensor muscle.

The changes which the bones, ligaments, and muscles undergo, vary, not only in the different species of clubfoot, but in the different stages of the same case. The greatest alteration appears to exist on the part of the tarsal bones, which, although they are rarely completely dislocated, are generally somewhat separated from each other, twisted around their axes, variously distorted, atrophied, or marked by irregular spicules or exostoses. The calcaneum, cuboid, scaphoid, and astragalus always suffer more than the other bones; which, however, as well as those of the metatarsus and of the toes, usually participate, more or less, in the deformity. The ligaments, in recent cases of clubfoot, are not materially changed, but in those of long standing, or in the higher grades of the affection, they are invariably stretched in the direction of extension, and relaxed in that of flexion. In some instances the original structures are partially replaced by bands of new formation, of a dense, fibrous character, the volume and resistance of which vary according to the duration of the disease, and the pressure of the parts which they serve to connect. The muscles also are not much altered in the first instance, except that they deviate from their natural direction, and that, like the ligaments, they are elongated, on the one hand, and shortened, on the other. In ancient cases the whole limb is always considerably wasted, and many of the muscles are remarkably thin and pale, or even transformed into soft, fatty bundles. The cellular substance is condensed and diminished in quantity; the fat is absorbed; and even the vessels and nerves supplying the affected parts are reduced in volume. The skin of the foot, which receives the principal brunt of the pressure in standing and walking, is generally very much thickened and indurated, and large synovial bursae are often formed beneath it, which are apt to inflame, and thus add to the suffering of the patient.

Clubfoot, both congenital and acquired, is liable to be complicated with various affections, interfering, more or less, not only with the comfort of the patient but the permanent restoration of the limb. Among the more common of these defects are corns and bunions, cutaneous cicatrices from burns, scalds, or ulcers, ankylosis of some of the joints, and deviation, absence, or increase of the number of toes. Fortunately nearly all of these complaints admit of relief by treatment.

Treatment.—The treatment of clubfoot should always receive early and efficient attention, for the longer it is deferred the more difficult it will be, other things being equal, to effect a cure. This is equally true of the congenital as of the accidental form of the affection. The bones in early life, and in recent cases of deformity, are much more easily restored to their normal position than in youth and adolescence; and the muscles also regain much sooner, as well as more completely, their native power. In the worst grades of the lesion, it is generally extremely difficult, if not impossible, when treatment has been neglected until after the age of puberty, to make a satisfactory cure without the division of a considerable number of tendons, and the necessity of compelling the patient to wear, for a long time, various kinds of apparatus.

The precise period at which the treatment should be commenced has been variously defined by different authorities. Provided the infant is healthy, my custom has long been to begin it as early as the end of the second month, and, unless the case is very bad, I have rarely found it necessary, at this early period, to do more than confine the limb in a well-adjusted apparatus, worn steadily day and night. When the distortion is considerable, I invariably employ the knife as a preliminary measure, and this may always be done with the most perfect safety, even within the first four or five weeks.

Different kinds of apparatus are in vogue for the cure of clubfoot, and it is, therefore, not always easy for the practitioner to determine which is the best, or which should be employed to the exclusion of others. Every orthopædic surgeon, almost, has some peculiar notions upon the subject, which induce him to adopt such measures as whim, fancy, or experience may dictate. This very circumstance, however, goes to show that the same end may be attained by different means. Whatever plan be adopted, the great caution to be observed, on the part of the surgeon, is that the

extension be made in a slow and gradual manner, that the skin be protected from friction and unequal pressure, that the dressing be worn day and night, and, finally, that the limb be frequently washed, and immediately afterwards rubbed with some mild sorbefacient lotion. The object of these instructions is self-evident, and must be constantly borne in mind in our curative procedures. During the first few days, the apparatus should be applied rather loosely, until the limb has become accustomed to its presence, when it must be gradually tightened. If the skin becomes chafed, hot, and tender, measures must immediately be adopted to moderate or shift the pressure, or the apparatus must be left off altogether for a few days. In young children, the skin is so delicate that, unless the greatest caution is used, the foot may be seriously injured before any one is aware of it. By inattention to this rule, I have seen deep ulcers produced, which greatly interfered with the subsequent management of the case.

The time required for restoring the limb to its normal position must necessarily vary in different cases, and must depend upon so many circumstances as to render it impossible to lay down any specific rule. From two and a half to six months, however, may be regarded at a fair average, although occasionally a much longer period will elapse, even under the most unremitting attention. The division of the faulty tendons always materially expedites the cure, and I, therefore, almost invariably employ it, however simple the case.

Mr. Richard Barwell, of London, considers tenotomy as a remedy for clubfoot entirely unnecessary; and in a monograph, published in 1846, he has described and delineated an apparatus which, if properly applied, will, he thinks, be generally sufficient for effecting a speedy and permanent cure in almost every instance of this affection. His opinion is that the tendo Achillis is almost the only muscle that should ever be divided. The means upon which he mainly relies for rectifying the faulty position of the foot are, adhesive strips, longitudinal and circular; a piece of turned iron about an inch in width, as long as the child's leg, and provided at its upper extremity with a wire loop; a few India-rubber cords of various lengths by three lines in diameter; and some eyelets, with pincers for fixing them. The object of the whole proceeding is to aid the affected muscles in regaining their action upon the foot, by compelling them to adapt themselves to the normal posture.

Mr. Barwell's plan of treatment is warmly advocated by Dr. Sayre and other eminent surgeons. As an exclusive practice, it cannot, I think, be too pointedly condemned.

While in some instances it answers the purpose admirably, it is certain that in the great majority of cases tenotomy constitutes a most important preliminary step to a rapid and successful cure. My reasons for this statement are two-fold. In the first place, tenotomy, when carefully performed, is a perfectly harmless operation; and, in the second, the treatment pursued by Barwell, Sayre, and others requires an amount of skill and attention which few practitioners can command.

A great variety of clubfoot apparatus has been constructed during the last twenty-five years, all based upon the original well-known shoe of Scarpa. The adjoining sketch, fig. 758, affords a good idea of what such a contrivance ought to be, and, under the superintendence of any accomplished cutler, it may readily be made with the aid simply of a plaster cast, which may now be sent by express to any part of the country. The essential elements of the apparatus are a shoe and two side-pieces, extending as high up as the lower third of the thigh, the whole being so arranged by means of screws as to permit the angle of flexion to be regulated at pleasure. The shoe, composed of soft leather, well padded, and laced in front, has a steel sole, consisting of two pieces, moved by a concealed screw, the spring of which projects at the side. In this way the foot may readily be turned to one side or the other, according to the exigencies of the case,

while it is depressed or elevated by an oblique screw at the ankle, connecting the shoe with the leg-piece of the apparatus, and worked by a key, as seen in the accompanying drawing. The lateral steel rods are so constructed that they may be

Fig. 758.



Clubfoot Apparatus.

lengthened or shortened at will, and are fastened by means of well-padded straps, each inclosing a semicircular piece of steel behind, in order to afford proper support to the limb in that situation. They are united, opposite the knee, by a hinge-joint, to permit the full play of that articulation.

There is an apparatus, differing from the preceding chiefly in having only one side-piece, and in being worked by an endless screw, situated opposite the ankle. Its great value consists in the facility which it affords for depressing the displaced margin of the foot.

In the calcaneal form of the affection, attended with great depression of the heel and inordinate contraction of the plantar arch, the most suitable apparatus, after the division of the faulty tendons, is the one depicted in fig. 759. Its construction and mode of action will be understood at a glance, without the aid of any description. By means of the spring or elastic cord attached to the back part of the apparatus the heel is gradually forced up, and the foot proportionately lowered, until the defect is permanently remedied.

The *division* of the faulty tendons requires more care and attention than is usually imagined. Every tyro in surgery thinks he can easily effect it; but this is a great mistake. To do it well requires skill, judgment, and a perfect knowledge of the anatomy of the foot and leg. It is this presumptuous interference that has brought so much obloquy upon the operation. Very little, if any, preliminary treatment is generally necessary. If the child, however, is several years old, and has been accustomed to much exercise, it will be well to keep him at rest for a few days before the operation, to wash the foot repeatedly with cold water, and to enjoin a light diet. The operation may then be commenced, chloroform being given or not, according to circumstances, and every faulty muscle being divided at one sitting. The position of the patient must necessarily vary according to the exigencies of the case.



Fig. 759.

Apparatus for Calcaneal Clubfoot.

The number and nature of the tendons requiring division vary with the extent and character of the distortion. Thus, in simple equinus or phalangeal clubfoot, the tendo Achillis alone being concerned in producing the affection, the operation must accordingly be restricted to that cord, and the effect is generally such that, if the patient is able to walk, no apparatus will afterwards be needed to bring down the heel. Pure, uncomplicated varus requires the division of the tendon of the anterior tibial muscle, or of this muscle and of the long flexor of the toes. In the more simple forms of valgus, the tendons of the peroneal muscles are mainly concerned; while in calcaneal clubfoot the distortion depends upon the contraction of the anterior tibial and common extensor muscles of the toes. In equino-varus, and in the worst forms of clubfoot generally, more or less extensive division of the plantar aponeurosis is required.

Age is no bar to tenotomy. I have repeatedly performed the operation within the first two months after birth, and I should not object to it, if the child were perfectly well, and the distortion very great, within the first fortnight, although, as a general rule, it is best to wait a longer time. Young adults are often immensely benefited, and sometimes entirely relieved, by the operation; and cases have been reported of excellent results in persons of forty and even fifty years of age.

The tenotome which I am in the habit of using is represented in fig. 760; it is nearly six inches in length, of which one inch and three-quarters are occupied by the blade. The cutting portion of the blade is spear shaped, very sharp, thin, and a little more than five-eighths of an inch in length by two-thirds of a line in width at its widest part. The instrument, of course, makes a mere puncture in the skin.

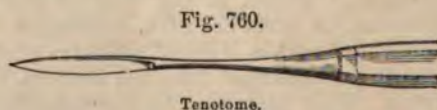


Fig. 760.

Tenotome.

In dividing the *tendo Achillis*, the patient is placed upon his abdomen, and the limb, extended upon the table, is firmly held by an assistant. The operator, sitting in a chair, grasps the foot with his left hand, and, bending it over the edge of the table brings down the heel as far as possible. The necessary tension being thus

given to the tendon, the knife is entered flatwise between it and the deep-seated structures, a full inch above the calcaneum, and pushed on until it reaches the opposite side, care being taken that the point does not pierce the skin. The instrument is now turned in such a manner as to bring the edge of the blade against the anterior surface of the cord, which is then completely severed by pressing the handle steadily and firmly backwards, with a kind of sawing motion. The division of the parts is generally indicated by a distinct snap, and by the immediate cessation of their resistance. The operation, which is soon over, is attended with hardly any pain, and with the loss only of a few drops of blood. The only danger is the wounding of the posterior tibial artery, but this may easily be avoided simply by keeping the knife in close contact with the anterior surface of the tendon, and cutting from before backwards. The puncture may be made on the inner or outer side of the limb, as may be most convenient.

Professor Pancoast, instead of severing the tendo Achillis, prefers, in most cases attended with retraction of the heel, the division of the inferior portion of the soleal muscle, on the ground, not only that the procedure is free from danger, but that it admits of the more rapid rectification of the deformity. The operation, which he has performed a number of times, is, however, applicable only where there is marked tension of the soleal with relaxation of the gastrocnemial muscle.

The tendon of the *posterior tibial muscle* is cut most conveniently about an inch and a quarter above the inner ankle, the patient lying on his side, with the inner surface of the leg looking upwards. The operation is conducted upon the same principles as in dividing the tendo Achillis, and the only precaution necessary is to avoid the posterior tibial artery and nerve, which might be endangered by carrying the knife too deeply. The tendon of the long flexor muscle may be severed at the same point. In the slighter cases of distortion, the tendon of the posterior tibial muscle may be cut below the ankle, in its passage to the scaphoid bone, but in the more aggravated forms such a procedure is impracticable on account of the concealed situation of the cord. The tendon of the flexor muscle of the great toe may be divided in the sole of the foot, where, when it interferes with the rectification of the limb, it forms a tense, prominent cord.

The most favorable situation for dividing the tendon of the *anterior tibial muscle* is in front of the ankle-joint, where it may usually be readily felt as a tense cord, lying somewhat nearer to the internal malleolus than in the natural state. The patient rests on his back during the operation, and care is taken not to wound the anterior tibial artery.

The tendons of the *peroneal muscles* are most easily divided a short distance above the outer ankle, as they run over the fibula. The operation will be facilitated if, as the knife is carried outwards towards the surface, the foot is rotated downwards and inwards, the cords being thus rendered more tense.

In dividing the *plantar aponeurosis* the knife is inserted flatwise beneath the skin, and made to cut from before backwards, the patient lying upon his back, and the foot being put on the stretch. As the aponeurosis is extremely dense and firm, its division generally requires a very sharp, well-tempered knife, worked with a kind of sawing motion, the finger resting the while on the skin immediately over it, to prevent it from cutting through. It is seldom necessary to divide more than two bands, one in the posterior part of the sole, and the other at the inner margin of the foot, corresponding with the metatarsal bone of the great toe.

As soon as all the faulty structures have been thoroughly divided, the foot is well flexed and extended, in order to break up any morbid adhesions that may exist, and separate as widely as possible the ends of the tendons, as much force being used for this purpose as may seem to be compatible with the safety of the limb. The advantage gained in this way is generally very great, and it is remarkable how tolerant the parts are of manipulation. The little puncture made in the operation is covered with a strip of adhesive plaster, and usually closes in a very short time. The limb, bandaged from the toes up, is immediately placed in an appropriate apparatus. This plan has been constantly pursued by me for many years, and I have never had any cause to regret it; on the contrary, I believe it to be decidedly preferable to waiting three or four days, as usually recommended; for at the end of this time the parts are often so tender as to be quite intolerant of pressure and extension. It is only in cases of an extraordinary character that this rule should be deviated from. There need be no apprehension of a want of reunion of the ends of the divided

tendon when this course is adopted. I have myself never met with such an occurrence, nor heard of one that was entitled to credence. The apparatus must, of course, be applied rather loosely at first, and be gradually tightened as the limb becomes more tolerant of its presence. It should be taken off regularly every day, in order that the limb may be freely washed and rubbed with some mild sorbefacient lotion, as well as subjected to passive motion; a circumstance of great importance in respect to the welfare of the ankle-joint, and the restoration of the muscles of the limb. For the first five or six days after the operation, the limb is kept at rest in an elevated position; after that time the patient may be carried about or walk with the aid of a crutch or stick, as may be found most convenient. The apparatus must be worn day and night, for a period varying from three to twelve months, according to the severity of the case. When the patient is old enough to walk, and the deformity has been entirely overcome, it will be advisable to substitute for the ordinary apparatus, but only during the day, a less complicated shoe, fig. 761, which, by confining the foot in the normal position, without the necessity of adjustment, permits the ordinary movements of locomotion. It should be worn until further support can be dispensed with. If there be marked paralysis of the extensors, or if the contraction of the tendo Achillis have not been entirely overcome, the addition of an elastic band, as in fig. 762, will greatly expedite the cure. If the treatment is properly conducted, the patient and surgeon carefully coöperating, there will seldom be any necessity for a redivision of the tendons.



Shoes for the After-treatment of Clubfoot.

During the after-treatment, much benefit may be expected, in nearly all cases, especially in those of long standing, from the cold douche, friction with stimulating lotions, particularly such as contain veratria and ammonia, shampooing, passive motion, electricity, and Faradization, perseveringly continued until the weakened and degenerated muscles regain their normal character. The limb should be kept warm with worsted stockings; and the general health, if deranged, should receive due attention.

In simple equinus, occurring in childhood and young persons, I have never found it necessary to apply any apparatus, the heel rapidly coming down under exercise, which the patient may safely begin within a few days after the operation.

The interval between the ends of the divided tendons is gradually filled up with plastic matter, while the blood poured out in the operation is rapidly removed by the absorbents. As in other subcutaneous procedures, the plasma soon becomes organized, and is finally converted into a firm, dense substance, analogous to the original structure, which it is destined to replace. Observation shows that it is already quite firm and unyielding by the end of the first fortnight; a circumstance which proves how important it is to give due heed to the management of the extending apparatus.

The operation for clubfoot is occasionally attended with the puncture of some of the arteries, especially the anterior and posterior tibial. In such an event, the proper plan is to divide the wounded vessels, and to use graduated compression, or, this failing, acupuncture may be tried. Ligation is seldom necessary.

A false aneurism sometimes forms, especially when, after injury of an artery, no proper treatment has been employed, the blood then diffusing itself in every direction. The tumor, which is seldom circumscribed, is soft, elastic, and pulsates more or less distinctly as in similar affections elsewhere. The only resource is ligation of the vessel at both ends, although a case has been recorded by Mr. Adams, of London, of a speedy cure with an injection of ten drops of the concentrated solution of the subsulphate of iron, the femoral artery being compressed for five minutes before and after the operation.

The cutaneous puncture made in this operation is occasionally converted into an open wound, thereby endangering the occurrence of suppuration and even ulceration. Such an accident is most liable to happen during the division of the tendo Achillis,

when adhesions have formed with the skin after a previous operation. It may, also, as in several instances in my own hands, depend upon the presence of vicious cicatrices, the result of burns, scalds, or ulcers. The foot is at once extended and the wound closed with lint and adhesive plaster, confined with a compress and roller, the dressing remaining undisturbed for several days.

Suppurative inflammation of the sheaths of the divided tendons and of the surrounding cellular tissue is an occasional consequence of this operation, but its occurrence must be very uncommon, as I have never seen an example of it. It is most liable to follow the division of the deeper tendons, and must be managed upon general antiphlogistic principles.

Finally, whatever mode of treatment may be adopted, it is of paramount importance that it should be carried out under the personal superintendence of the surgeon; to delegate this office to the parent or nurse or to the patient himself, is only a waste of time, and what no sensible practitioner should ever do. I never, in fact, like to intrust the management of a case of clubfoot even to an intelligent physician, for there are so many points that demand attention that, unless the greatest possible care is exercised, something will be sure to go wrong, and mar the beauty of the cure.

The adjoining sketch, fig. 763, illustrates the effects of the division of the tendo

Fig. 763.



Effects of the Operation for Clubfoot.

Achillis and plantar aponeurosis, in a case of equino-varus, attended with bad deformity. The cure was perfect.

The operation for clubfoot, as stated in a previous chapter, was first satisfactorily performed in 1831, by Dr. Stromeyer, of Hanover. The tendo Achillis, however, was divided as early as 1784, by Lorenz, a surgeon at Frankfort, at the suggestion of Dr. Thilenius. The case was one of equino-varus, in a young lady who had suffered from birth. The operation was not performed subcutaneously, but by direct incision. The heel descended two inches; and, although the cure was tedious, the patient finally obtained a good use of the limb. A similar operation was performed not long afterwards by Sartorius; he made

his incisions still larger than Lorenz, and it is, therefore, not surprising that he should have signally failed. Michaelis, at a somewhat later period, modified the procedure by dividing the shortened tendon partially, and immediately bringing down the foot by mechanical appliances. His first operation was performed in 1809. In 1816, Delpech, of Montpellier, whose name is indelibly associated with this department of surgery, conceived the idea of performing the operation subcutaneously, and he accordingly carried it into effect in a case of varus conjoined with retraction of the heel. What is remarkable, however, and what greatly marred the success of the result, was that he should have made, as a preliminary step, an incision an inch in length through the skin and deep-seated structures on each side of the tendo Achillis, evidently with a view of facilitating the division of the cord from behind forward. After much trouble and not a little suffering the patient ultimately made a tolerably good recovery, but Delpech was so much discouraged that he never ventured to repeat the operation. Such was the state of tenotomy when Stromeyer, fifteen years later, entered the field, and, perceiving the errors of his predecessors, laid down the proper principles which should guide the surgeon in the execution of his task.

FLATFOOT.

This deformity, which is most common in young adolescents, occurs in both sexes and in all classes, usually from some inherent congenital defect in the structures of the foot, aggravated by overwork, by the use of imperfectly constructed shoes, or by vicious eversion of the foot, in attempts at polite walking. It is often associated with disorder of the general health, and is most frequently met with in per-

sons of a strumous predisposition, with a tendency to rachitis. Although it sometimes begins very early in life, it seldom becomes a source of deformity until after the age of fourteen. Both feet commonly suffer simultaneously, but not in the same degree.

The affection, as seen in the annexed sketch, fig. 764, essentially consists in a loss of the arch of the foot, so that, when the individual stands up, the sole rests flat upon the ground, instead of upon the heel and the ball of the toes. The external malleolus is uncommonly prominent, the foot inclines outwards, as in the milder forms of valgus, and the ankle is remarkably large and full. In the worst forms of the affection, there is partial displacement of the scaphoid, astragalus, and internal cuneiform bones, the convexity of the dorsum is lost, the toes are everted, and the foot is considerably elongated. The ankle-joint, at all times weak, eventually loses its mobility, and the patient is permanently crippled and deformed, progression being difficult, awkward, and painful. The internal lateral ligament is attenuated and relaxed, while the peroneal, tibial, and extensor muscles are shortened, and not unfrequently affected with the fatty degeneration.



The treatment, in the earlier stages of the complaint, consists in the use of the cold douche, followed by friction with some stimulating liniment, and aided by mechanical support of the ankle, as a shoe or boot with side-pieces and a screw for inverting the foot. The sole should be considerably thicker on the inner than on the outer side. The general health is amended, if necessary, by tonics and change of air. Absolute rest of the limb is sometimes of the first importance, in order to afford the weakened structures an opportunity of becoming invigorated, exercise being taken, in the mean time, in a carriage or swing.

In the more serious forms of flattening, attended with great eversion and more or less elevation of the toes, recourse must be had to tenotomy, with the subsequent employment of a rectifying apparatus. The treatment, in fact, must be very similar to that of valgus. The muscles whose tendons require division are the peroneal, the anterior tibial, and the long extensors of the toes.

PERFORATING ULCER.

Under this appellation, Delsol, of France, has described a disease which, usually commencing as a callosity on the sole of the foot, at the root of one of the metacarpal bones, gradually terminates in an undermined, ill-looking ulcer, with a dark, foul bottom, and a peculiarly offensive, sero-purulent discharge. It is surrounded by a wall of thickened epidermis, and its edges are so steep as to give it the appearance as if it had been made with a punch. As it progresses, it erodes the ligaments and periosteum, and finally penetrates the contiguous joint, followed by softening and caries of the bones. If not checked, the inflammation spreads among the adjoining structures, causing extensive purulent infiltration, and such a degree of disorganization as to necessitate amputation.

The character of this complaint is obscure. It has been supposed by some to be due to a syphilitic taint; others, on the contrary, imagine it to be of the same nature as senile gangrene, especially as it is most commonly met with in elderly subjects, in connection with calcification of the coats of the arteries. It is obviously not carcinomatous. The first appearance is usually a thickening of the epidermis, like that of a corn, but more extensive and painless. The disease may last for weeks and months, and is then nearly always attended with severe local and constitutional disturbance.

The treatment consists in thorough division of the parts, and in the application of iodine followed by lotions of acetate of lead and opium. Leeches will be beneficial when there is much swelling, conjoined with discoloration and pain. Purulent infiltration must be relieved with the knife. Amputation will be required when there is extensive disorganization of the joint, bones, and tendons. The exhibition of some of the iodides and of mercury is indicated when the complaint is obviously of a syphilitic origin.

PODELCOMA.

A peculiar ulcerous affection of the foot, known under the name of podelcoma, is occasionally met with. Its precise nature is not well understood, some regarding it as of a scrofulous, others as of a syphilitic, character. It occurs in both sexes and in different classes of individuals, and is most frequent in persons of middle life, of a broken constitution.

Commencing usually about the toes, the disease is characterized by the occurrence of numerous small sores, separated by thickened and indurated skin, their edges being steep and abrupt, and their surface incrustated with aplastic lymph. Their shape is generally oval or circular; sometimes, although rarely, several run together, or are connected merely by narrow, undermined bridges of integument. The discharge is foul, fetid, sanious, and irritating. The pain is usually very severe, and there is always serious constitutional involvement, the patient being thin, wan, weak,

and fretful. In cases of long standing, the disease is not limited to the soft parts, but affects the other structures also. The nails ulcerate and drop off; the phalanges of the toes are rendered carious; and the calcaneum and metatarsal bones ultimately experience a similar fate. The frightful changes which this disease is capable of producing in the foot are well illustrated in the annexed cut, fig. 765.

The natives of India are subject to a form of podelcoma, due, as has been shown by Carter, Berkeley, and others, to the presence of a mucedinous fungus, which works its way into the bones of the tarsus, metatarsus, and lower ends of the tibia and fibula, causing much pain, swelling,

and deformity, tunnelling through the tissues of the entire foot by numerous apertures and fistulous routes, attended with much fetid, irritating, and unhealthy discharge, and eventually, unless amputation be performed, producing death by exhaustion. The affection is popularly known in India as the Medura foot.

In the treatment of this disease, great advantage may be derived from a regular and persistent course of iodide of potassium along with iodide of iron and bichloride of mercury. Quinine and brandy will be required if much debility exist. The best topical remedies are emollient cataplasms or warm water-dressing, with the free use of the chlorides, to allay fetor and promote cicatrization. The nitric acid lotion will also prove useful; and many cases will do well under the application of calomel, or calomel and tannic acid, with dry lint. In the worst forms nothing short of amputation will answer the purpose.

PODODYNIA.

This disease, hitherto undescribed, although not peculiar to tailors, is so common among them that it might very properly be called after their name. It is most frequent among cutters, in consequence, apparently, of their being compelled to maintain for many successive hours every day the erect posture, after they have been accustomed to sit for years upon the board. The feet, being thus suddenly exposed to great hardship, are unable to bear the continual pressure imposed upon them by the weight of the body, and the result is that they become exceedingly tender and painful, if not, in time, entirely disabled. The soreness is generally most severe in the sole of the foot, over the calcaneum and the ball of the great toe, or in the line of the metatarso-phalangeal joints, parts which are particularly subject to pressure during the erect posture. The hollow of the foot, however, occasionally participates in the suffering. The pain and tenderness are deep seated, and are always aggravated by the pressure of the finger, and by walking and standing, which the patient is often obliged to forego in consequence. Little swelling attends the disease, and there is seldom any marked discoloration of the skin. Both feet often suffer simultaneously. The general health is seldom materially, if, indeed, at all, affected.

What the pathology of pododynia is I have not been able to determine, as no

Fig. 765.



Podelcoma: *a*, the Toes much altered; *b*, the Outer Side of the Foot, in some Parts showing Cicatrices; *c*, the Line of Amputation, at the Ankle; *d*, the Astragalus. The Swelling is often much greater than here represented.

opportunity has been afforded me of dissecting the parts. The probability is that it is a form of inflammation, chiefly of the periosteum, or of the periosteum and plantar aponeurosis, attended with an inordinate determination of blood and a slight tendency to effusion. In the cases which have fallen under my observation, it has not been in my power to trace any connection between this disease and gout or between it and rheumatism. The subjects are, for the most part, young men.

The treatment which I have found most efficacious in pododynia has been a succession of blisters, with rest and elevation of the foot, and some attention to the diet and bowels. Medicated lotions, tincture of iodine, and leeching have exerted no special influence upon the progress of the disease. In a few cases I have tried, but without any material benefit, subcutaneous scarification of the affected parts. Colchicum has been of no service in my hands.

TUMORS.

Various kinds of morbid growths, benign and malignant, are liable to occur in the foot, both upon its dorsal and plantar surfaces. Of the former, the most common are the fibrous and fatty; of the latter, the encephaloid and scirrhus.

The *fibrous tumor* is most frequent on the posterior part of the sole of the foot, where it often sadly interferes with progression; it is generally situated immediately beneath the skin, imparts a firm, slightly elastic sensation to the finger, is of a rounded, elongated shape, tardy in its growth, more or less vascular, and liable to return after extirpation. The history of the case, and a careful examination of the tumor, will usually reveal its true character.

The *fatty tumor* of the foot is uncommon; it is free from pain, of slow progress, lobulated, and of a doughy, inelastic consistence. The skin is usually sound. I have heard of a tumor of this kind in the foot, of the size of a large fist, for which the leg was amputated. A similar case has been reported by Mr. Gay, of London. In this case the tumor was congenital, and occupied the sole of the foot, which was amputated under the belief that the growth was of a recurrent, if not of a decidedly malignant, nature.

A rare case of *hygromatous tumor* of the foot, in a girl fifteen years of age, has been related by Dr. J. F. Heyfelder, of St. Petersburg. It had made its appearance six years previously without any assignable cause, fluctuated distinctly under pressure, was free from pain but interfered with the wearing of the boot, and extended along the outer side of the foot from the tendo Achillis to the third, fourth, and fifth toes. The introduction of a trocar gave vent to a thick, turbid fluid, the flow of which was impeded by numerous small granular bodies. A cure was effected by the injection of a mixture of iodine, iodide of potassium, and water.

Malignant tumors of the foot pursue the same course as similar growths in other parts of the body. Their diagnosis is generally easily determined by their history. The only remedy is early and thorough excision. When extensive involvement exists, nothing short of amputation of the leg will answer.

2. AFFECTIONS OF THE LEG.

BOWED LEG.

This affection, familiarly known as the "bowed" or "bandied" leg, consists in an excurvation of the tibia and fibula, attended with a peculiarly arched appearance of the limb, as exhibited in fig. 766, and a singularly awkward gait of the individual. It occurs in various degrees, from the slightest deviation from the normal standard to the most unseemly deformity. The tibia generally suffers more than the fibula, although the latter is seldom entirely free from the defect. The curve is usually lateral, the bone being concave internally, and more or less convex externally. In the worst forms of the affection there is also an anterior curvature, or the curvature may exist exclusively in front.

Both limbs are commonly affected, although not always in an equal degree. The deformity is sometimes associated with malformation of the thigh-bones, spinal curvature, and a stunted condition of the whole body, especially when it is the result of rachitis. It is also not uncommon to meet with serious malformation of the knees, ankles, and feet, the latter of which are often greatly turned out.

Fig. 766.



Bowed Leg, in a High Degree.

The immediate cause of bowed leg is softening of the osseous tissue, from defect of earthy matter. This may depend either upon rachitis or upon some other vice of the constitution, the precise nature of which cannot always be determined. The exciting circumstances are two,—contraction of the muscles pulling the affected bones out of shape, and the weight of the body compelling them to bend under the superimposed pressure. In rachitis the curvature is frequently attended with actual shortening; the latter defect, however, often exists without the former, the pieces in which it is most marked being perfectly straight.

The treatment must be early and decided. If it be postponed until the completion of the ossific process, it will be in vain to hope for relief. The general health, if at fault, must be amended by appropriate remedies; walking and standing must be interdicted; and the limbs must be supported by suitable apparatus, applied in such a manner as to make efficient counter-pressure opposite the seat of the excurvation. The more simple forms of the lateral variety will generally yield to a light, well-padded wooden splint, fig. 767, stretched along the inside of the leg and inserted by a tubular socket into the heel of a laced boot. It should extend from the malleolus to the upper part of the condyle of the femur, and be fastened by means of strong webbing long enough to pass twice around the limb and splint, and secured with straps and buckles. The object of this arrangement is to exert the greatest amount of pressure upon the line of curvature. In the more severe grades of the affection, nothing will be found to be more efficient than the apparatus delineated in the annexed cut, fig. 768.

Fig. 767.



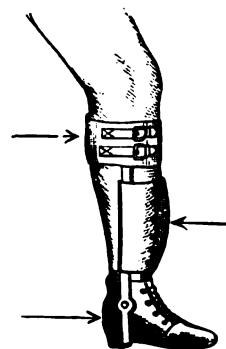
Bigg's Apparatus for Lateral Curvature of the Leg.

Fig. 768.



Kolbé's Apparatus for Bowed Leg.

Fig. 769.



Apparatus for Anterior Curvature of the Leg.

For the relief of the anterior curvature, the best apparatus with which I am acquainted is that of Mr. H. H. Bigg, of London, represented in fig. 769. It simply consists of two stout uprights inserted into the side of a boot and attached above to a metal band fitted to the posterior surface of the leg, and fastened by means of straps around the head of the tibia. The requisite degree of pressure is made with two leather bands secured to the vertical pieces, and laced in front. In the antero-lateral or double curvature, the apparatus must be so constructed as to bear simultaneously against the front and side of the limb.

Whatever contrivance be used, care must be taken to watch its effects, otherwise

it may, by its pressure, cause severe pain and even ulceration. It should, if possible, be worn day and night. The limbs should be well washed once in the four-and-twenty hours, and bathed with a strong solution of alum.

When the deformity cannot be overcome by means of appropriate apparatus, the only thing to be done is to fracture the affected bones; or, when this is impracticable on account of the excessive hardness of the osseous tissues, to perforate them subcutaneously at a number of points until their substance is sufficiently weakened to yield to the efforts that may be made to break or bend them to the requisite degree. Such a procedure, if properly executed, is generally entirely free from danger, and always greatly facilitates the cure.

Tenotomy is of no use in these malformations. In the few cases in which it has been practised, it did not seem to have been even of any material temporary benefit.

VARIX.

Varix of the lower extremity is a very common disease in both sexes, and often entails much suffering. In general, it involves both the leg and foot, while not unfrequently it extends even into the thigh, being particularly conspicuous along the course of the saphenous vein and its branches. An excellent illustration of this affection will be found in fig. 288, in the chapter on the diseases and injuries of the veins, to which the reader is referred for a full account of it.

The treatment is palliative and radical. In the milder cases, very little is generally required beyond attention to cleanliness of the parts, the avoidance of all constriction of the limb, and the exhibition, now and then, of a purgative, especially in pregnant females. If the patient is very plethoric, much benefit will be experienced from an occasional bleeding. The limb should be frequently washed with cold water, or sponged with some alcoholic lotion, and kept as much as possible at rest in an elevated posture. With the aid of these measures, the use of a laced stocking, fig. 770, or a well-applied bandage, the milder cases will commonly be sufficiently manageable.

Fig. 770.



Laced Stocking.

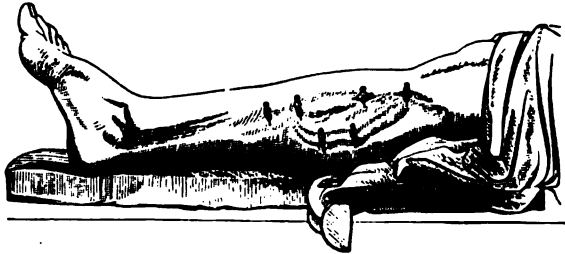
For the radical cure, various remedies have been suggested, the safest, as well as the most effectual, of which are the caustic issue, constriction with the twisted suture, subcutaneous ligation, and injections of subsulphate of iron. Excision and direct exposure of the diseased vessels are too dangerous to be practised.

The treatment by the *caustic issue* has been eminently successful in my hands, and I, therefore, give it a decided preference. It consists in making a number of eschars with equal parts of caustic potassa and quicklime, converted into a consistent paste with alcohol. Of this, a portion of the size and shape of a three-cent piece, only much thicker, is placed directly upon the enlarged and tortuous vessel, at intervals of three, four, or five inches, and allowed to remain for fifteen minutes, by which time the skin and cellular tissue will have been thoroughly destroyed. The paste is now removed, and the parts, carefully washed with vinegar, to neutralize any of the alkali that may still adhere to the surface, are covered with an emollient poultice, for the purpose of promoting, first, the separation of the eschars, and, secondly, the development of granulations. The cure is usually somewhat tedious on account of the length of time required to heal the issues, but it possesses the great advantage of being entirely free from danger and always perfectly successful.

Constriction of the diseased vessels may be performed by passing underneath them, at different points, long, ordinary suture pins, and drawing tightly around each of them a stout, well-waxed thread, so as to arrest at once the circulation both within the veins and also in their tunics, as delineated in fig. 771. Some surgeons interpose a piece of wax bougie between the skin and ligature, as in fig. 772, but I do not believe that this adds anything either to the comfort of the patient or to the success of the operation. Great care must be taken that the pins are carried fairly behind the vein, for, if they transfix it, very serious phlebitis may arise, whereas, if the procedure be properly executed, it will generally prove harmless, although, as already observed, less so than the operation by caustic. The pins should not be removed until considerable ulceration has taken place, which will rarely be before the end of the sixth or eighth day.

Mr. Henry Lee, of London, has modified this operation by dividing the vein subcutaneously between the pins as soon as the blood in it is coagulated. It is difficult

Fig. 771.



Obliteration of Varicose Veins by Ligation.

Fig. 772.

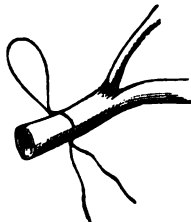


Twisted Suture.

to perceive the advantages of such a procedure, as a mere incision carried across such a vessel could not prevent the speedy reunion of its extremities, evidently the object of the operation.

Subcutaneous ligation by means of a metallic wire, fig. 773, as originally practised by Dr. R. J. Levis, is a very safe expedient, preferable to the operation by constriction with the pin and thread. The operation is performed with a straight needle, from two and a half to three inches in length, with a sharp, angular point which perforates without cutting. The instrument is carried across the tissues with the same precautions as in the ordinary method, and in such a manner as to bring out at the same orifices both ends of the thread, which are then firmly twisted together, and cut off about half an inch from the surface. Spontaneous removal of the sutures will generally occur in from two to three weeks, especially if they are occasionally tightened. Dr. Levis, up to 1864, had performed this operation successfully in thirty-eight instances, without any accident or unfavorable result. Dr. Bozeman effects subcutaneous ligation of the enlarged vessels with his button suture.

Fig. 773.



Subcutaneous Ligation
of a Varicose Vein with
Silver Wire.

The blood after this operation is occasionally completely devitalized, the more especially when portions of the enlarged vein are transformed, as it were, into so many distinct sacs, some of them, perhaps, capable of containing from half an ounce to an ounce of fluid. When the blood, after having been solid, undergoes liquefaction, as indicated by fluctuation, it is an evidence that it is necrosed, and ought to be evacuated, as its absorption will then be impossible.

A cure of this disease has occasionally been performed by the *injection* of the enlarged vein with a solution of perchloride of iron, as recommended by Pravaz. The most suitable instrument for the purpose is the one depicted in fig. 302, in the chapter on aneurism; the vessel is firmly compressed, as a preliminary step, by means of the finger, or a pad and roller, and a few drops, generally not more than three or four, of the solution are slowly thrown into its cavity, the contents of which are immediately coagulated. The great objection to this mode of treatment is that, while it is not always successful, in consequence of the gradual absorption of the clots, it is occasionally followed by serious accidents, as violent erysipelas and even pyemia. Of 103 cases collected from various sources in 1862, by Dr. Sentex, of Bordeaux, 79 were cured, 19 were improved, 16 were failures, and 1 perished. Dr. James M. Minor and others have employed subsulphate of iron equally successfully, the solution consisting of one part of the officinal preparation to four of water.

Whatever mode of treatment be adopted, the case should receive every possible attention until all danger from erysipelas, phlebitis, and pyemia is passed. The great object should be to restrain the inflammation that must necessarily supervene upon the operation within proper limits, for, if it be allowed to diffuse itself, the danger will be increased an hundred fold. The limb, invested with a roller, is placed in an easy, elevated position, and is kept constantly wet with water-dressing, simple or medicated, the diet and bowels being at the same time thoroughly regu-

lated. Premature exercise must be avoided, and the leg must for a long time be supported with a bandage or laced stocking.

Although surgeons are in the habit of speaking of the radical cure of varicose veins, it is questionable whether such a result is ever permanently obtained in any case, however complete the obliteration may be at the time. Gradually the collateral veins augment in size, and eventually, in many cases, become as troublesome as those originally affected.

When a varicose vein of the leg gives way by ulceration, serious, if not fatal, hemorrhage may be the result, the blood, perhaps, gushing out in a frightful torrent. The proper treatment is to clap the finger on the sore, remove the garter, elevate the heel, and place the patient on his back. Equable pressure with a compress and roller will also promptly arrest the bleeding.

ANEURISMAL VARIX.

This rare form of disease is occasionally observed in the leg, or leg and foot. The most remarkable example of this kind I have ever seen, in any part of the body, came under my observation in 1858, in a woman, forty-three years of age, an in-patient of the College Clinic. The varicose enlargement extended from the base of the toes as high up as the knee, affecting both the superficial and deep vessels. Pulsation was perceptible both by sight and touch, and a well-marked aneurismal thrill, most distinct over the posterior tibial region, was readily detected by auscultation. The internal saphenous vein was enormously distended in various parts of its course, being in some places nearly an inch in diameter, and the circumference of the limb was much greater than that of the sound one. The foot had a soft, spongy feel, and a deep, excavated ulcer, of the size of a ten cent piece, with a foul bottom and everted edges, existed upon its dorsal surface. The toes were distorted and enlarged, and near the instep a congenital nævus was found.

As the limb had been for years the constant seat of severe pain, and as the poor woman had long ceased to be able to walk without crutches, I amputated the leg a short distance below the knee. A large number of arteries and also the internal saphenous vein required ligation, the latter vessel being greatly enlarged, patulous, and unable to retract. The case went on tolerably well for eighteen days, when erysipelas and pyemia ensued, followed by an enormous abscess, extending from the stump to the crest of the ilium. The woman expired, completely exhausted, at the end of the fourth week. A full report of this interesting case, with an account of the dissection of the body and limb, from the pen of Dr. S. W. Gross, may be found in the Transactions of the Pathological Society of Philadelphia for 1861.

Fig. 774.



Monro's Apparatus for Maintaining Flexion in Ruptured Tendo Achillis.

LACERATION OF THE TENDO ACHILLIS.

This accident is always the result of the sudden and violent contraction of the gastrocnemial muscles, consequent upon inordinate exertion. It is most common in dancers and acrobats, beyond the middle age, and is probably generally connected with fatty degeneration of the substance of the tendon. The seat of rupture varies; but in most cases it is rather low down towards the heel-bone. The occurrence of the injury is commonly denoted by a loud snap, and by a sensation as if something had suddenly given way, the patient at the same time falling down, or finding it difficult to maintain himself on his limbs. The pain is very severe, and, on examining the parts, a distinct gap is discovered at the site of the laceration, similar to that which occurs in the operation for clubfoot.

In the treatment of this accident, the indication is to maintain perfect apposition of the ends of the ruptured tendon until complete consolidation is effected. Unless this be promptly met, a certain degree of lame-

ness will almost be inevitable. The apparatus that is usually employed for this purpose is that devised by *Monro*, and sketched in fig. 774. It consists simply of a slipper and a thigh-strap, connected by a cord, the object being thorough flexion of the limb, and consequent relaxation of the gastrocnemial muscles. If the strap have a tendency to slip, it must be secured to the pelvis. The indication may also be fulfilled by applying a splint along the front of the leg and foot, as in fracture of the heel-bone, the leg having previously been bandaged from the knee downwards so as to control the action of the flexor muscles, and the limb being afterwards placed in an easy, relaxed position, over a large pillow. A cure usually follows in about five weeks, but the patient must be very careful for some time after, otherwise the connecting bond will either give way, or, at all events, become injuriously elongated.

When, from neglect of proper treatment, or despite the best directed efforts, the ends of the tendons refuse to unite, the only remedy is to expose them by a free incision, and, after having cut off the offending structures, to connect the raw surfaces, rendered perfectly square, with metallic sutures. A number of cases are recorded in which the procedure was followed by complete success.

DISLOCATION OF THE TENDON OF THE PERONEAL MUSCLE.

The tendon of the long peroneal muscle is occasionally displaced by external violence, resulting in a rupture of its sheath. The accident is very uncommon. In the case of a youth, recorded by *Mr. T. B. Curling*, of London, the dislocation was caused by the foot slipping on a stone and turning outwards. The tendon presented itself as a projecting cord at the outer and anterior part of the ankle; and, although it was easily pushed back with instantaneous relief, yet there was a constant tendency to recurrence. Permanent retention was effected by the application of a piece of cork to the margin of the fibula, confined by a suitable bandage. The leg, after such an accident, should be placed in a semiflexed position, and kept perfectly quiet until the injured structures are thoroughly reunited.

FIBRO-CELLULAR ENLARGEMENT.

This affection was originally described in 1861, by *Mr. Furneaux Jordan*, of Birmingham, England. It presents itself in two varieties of form, which may occur either separately or conjointly. In the first, the enlargement completely encircles the leg immediately above the ankle-joint like a belt or collar, from two to three inches in height and from one and a half to two inches in thickness. The second form is more common; it consists in a slightly irregular, rounded or hemispherical projection, situated just below and behind the external malleolus. The enlargement, in whatever form appearing, is free from pain, tenderness, doughiness, pitting, and discoloration; is of gradual development; is most common in young persons, especially females, and is usually connected with valvular disease of the heart. The precise nature of the complaint is not determined. It certainly bears some analogy to elephantiasis, but differs from it in being softer and less diffused, and in not seriously involving the skin. The probability is that it has its origin in local inflammation, terminating in an effusion of plasma, and the organization and ultimate conversion of this substance into fibro-cellular tissue.

The treatment is by sorbifacients, as iodine and compression with the bandage. In the earlier stages, benefit will be derived from leeching and acetate of lead. The general health must be rectified.

3. AFFECTIONS OF THE KNEE.

ANCHYLOSIS.

Anchylolysis of the knee-joint is of frequent occurrence, and may depend, first, upon contraction of the hamstring muscles; secondly, upon disease of the ligaments and bones of the joint; and, thirdly, upon adhesions of the articulating surfaces, the union being either of a fibrous or osseous character. However induced, the limb will be sadly in the way of usefulness when the leg is straight, or flexed at a right angle with the thigh.

When the ankylosis is caused by permanent contraction of the hamstring muscles, a cure may generally be readily effected by the division of their tendons, passive motion of the joint being afterwards regularly maintained to prevent relapse. The operation is sufficiently simple, but requires some care to avoid the nerves and vessels in the neighborhood of the affected structures. Forcible extension with the hand should be practised immediately after the section has been completed, and the subsequent treatment should be conducted by means of a hollow splint, composed of sheet iron, well padded to ward off pressure, worked by a screw, and applied to the posterior surface of the joint. The treatment must necessarily be tedious, demanding both patience and skill, but by proper perseverance a good cure may be effected. The best apparatus for keeping up the requisite extension is that sketched in fig. 775, which may be readily manufactured by any respectable cutler.

When the ligaments and bones are at fault, as when there has been serious disease, resection may be required. Fibrous ankylosis, even when of long standing, may usually be effectually overcome by forced flexion under chloroform, the procedure being generally well borne both by the part and system, the slight pain and inflammation consequent upon it commonly disappearing in a few days. When the connection is osseous, either Barton's operation may be performed, or, what is preferable, the adhesions may be broken up subcutaneously by means of perforators and other instruments, as described in the first volume, in the chapter on ankylosis. I have now performed this operation successfully in four cases, the first being that of a young man, who was under my charge at the College Clinic in 1862, and who, notwithstanding the apparent severity of the manipulations, recovered without the occurrence of a solitary untoward symptom. The ankylosis, caused by a wound, had existed for nine years, and the natural structures of the articulation had been completely annihilated. The leg was flexed nearly at a right angle with the thigh. I believe that such an operation will always be perfectly safe when a joint is thoroughly deprived of cartilage and synovial membrane, and care is taken not to inflict serious injury upon the soft parts.

When the knee is retrocurved, or turned backwards, a very uncommon occurrence, the treatment must be conducted upon the same general principles as in the more ordinary forms of the accident. If the subcutaneous method should fail, or be inapplicable, relief should be attempted by Barton's operation, although certainly a much more dangerous procedure.

KNOCKKNEE.

Knockknee is an affection in which, as the name implies, the knee is turned inwards in such a manner as to touch its fellow of the opposite side, the leg being at the same time inclined outwards. When both knees are involved, and the deformity exists in a high degree, the lower extremities, when the individual stands up, represent pretty accurately the outline of the letter X inverted, the upper part corresponding to the thighs, and the lower to the legs, as seen in the accompanying cut, fig. 776. The feet are widely separated from each other, and are often so much everted as to compel the person to support the weight of his body principally upon the inner margin of the limb.

Fig. 775.



Extension Apparatus.

Fig. 776.



Knockknee.

The deformity thus occasioned is not only very unseemly, but, what is worse, produces a limping, awkward gait, which greatly interferes with progression.

Knockknee is always a noncongenital affection, although it is occasionally noticed at so early a period of life as to have led to the opinion, at one time sufficiently common, but now obsolete, that it is now and then an intra-uterine lesion. It occurs chiefly in weakly, delicate subjects, from the age of two years to that of eighteen or twenty. Children of a scrofulous habit and a rachitic predisposition are particularly obnoxious to it. So far as my experience enables me to judge, I am inclined to believe that the affection is considerably more frequent in males than in females, although some allowance must certainly be made for the fact that the difference in the clothing of the two sexes renders the former, when laboring under knockknee, a subject of much greater attraction than the latter, many of whom, simply in consequence of the difference in the dress, entirely escape detection, both in the house and in the street. The worst cases of this affection that have ever come under my observation occurred in negroes.

The immediate cause of this affection is a relaxed and enfeebled state of the internal lateral ligament, which allows the external hamstring muscle, one of the flexors of the leg, to drag the head of the tibia gradually outwards, away from the inner condyle. Whether the internal hamstring muscles, the semimembranous and the semitendinous, as they are termed, are originally involved in this partial displacement is not easily determined; but, however this may be, it is certain that they too become very soon relaxed and elongated, thus losing their antagonistic influence, and permitting their fellow on the opposite side to fall into a shortened and contracted condition, which, if not timeously remedied, only tends to a still further increase of deformity. The existence of this state of the parts has been verified by dissection, and may readily be ascertained by carefully examining a person laboring under knockknee, in the recumbent posture. The limb being turned in various directions, an opportunity is afforded of determining where the structures at and around the knee are most relaxed and most resistant. In the more aggravated forms of the affection, the crucial ligaments always participate in these changes in the natural relations of the parts; the bones of the leg are liable to be curved and otherwise altered, and the feet are either very much flattened, or more or less inverted, as in valgus. In such cases, the ankle-joint also usually becomes involved, the internal ligaments being attenuated and stretched, and the peroneal muscles more or less contracted.

The *treatment* of knockknee, in its more simple forms, admits of relief by mechanical means, such as a long, hollow, and well-padded splint, applied along the inner surface of the thigh and leg, so as to counteract effectually the contraction of the outer hamstring muscle, which is the active agent in the displacement. Or, instead of such a contrivance, the surgeon may employ the more elegant and efficient apparatus, sketched in fig. 777. The mechanical support should be assisted by a course of tonics, the shower-bath, and the cold douche, followed by stimulating lotions to the affected limb. In short, no pains should be spared to invigorate the general health, and to impart tone to the nervous system, which are so frequently at fault under such circumstances. The apparatus must be worn for a long time, inasmuch as the tendency to relapse is, in almost every case of the kind, remarkably great.

When the affection is obstinate, or exists in a high degree, the best plan is at once to divide the tendon of the two-headed flexor muscle; a procedure which is not only very simple, but extremely valuable in furthering the cure. In performing the operation, the patient is placed upon his abdomen, when, the limb being slightly flexed, a delicate tenotome is entered flatwise at the outer margin of the tendon, from an inch to an inch and a half above the knee, and passed on until it reaches the opposite side, when, the cutting edge being directed forwards, the division is easily effected in the usual manner. No vessel is in danger of being injured, but the peroneal nerve is occasionally cut, followed by slight paralysis, which, however, seldom lasts longer than a few months. Should

Fig. 777.



Apparatus for Knock knee.

the femoral aponeurosis be involved in the contraction, any hard and resisting bands that may present themselves may now be severed by a cautious use of the knife. The little punctures made in the operation being covered with bits of adhesive plaster, the limb is wrapped in a bandage, from the toes up, and placed in an easy posture over a pillow; or, what I prefer, the extending apparatus may be applied at once, as the resulting inflammation is generally so slight as not to require any special attention.

In knockknee, existing in a high degree, the external lateral ligament may sometimes be advantageously divided subcutaneously, a procedure which, under such circumstances, always greatly expedites the cure. Although the knife must necessarily enter the knee-joint, no harm will be likely to arise if the case be well managed afterwards, the little wound generally closing completely in a few days.

An affection the reverse of the preceding sometimes occurs, either in association with it or by itself. In the latter case, one knee is inverted, the other everted. The causes and the treatment are the same in both disorders.

LACERATION OF THE LIGAMENT OF THE PATELLA.

This accident may be produced by the same causes as fracture of the patella, that is, by the violent contraction of the extensor muscle at a moment when the leg is forcibly flexed upon the thigh, and the thigh upon the pelvis, thus throwing the ligament into a state of excessive tension. The rupture, whether occurring above or below the patella, is a very serious injury, liable to be followed by permanent lameness. When the ligament is torn away from the tibia complete reunion is not to be expected under any circumstances. Of 24 cases of rupture of the ligament above the patella, analyzed by Binet, in 14 it occurred during an effort to prevent a fall. In 3 instances it was caused by a fall, the leg being in a state of extreme flexion. It has also been observed to be due to voluntary muscular contraction, once by Petit during an effort to jump a ditch, and once by Sédillot by rapid running. Of 23 instances of rupture of the ligament below the patella, related by Binet, 8 were due to a false step, or during an effort to prevent a fall, 6 were produced by a fall, the leg being in the flexed position, and in 1 it was caused by rapid running.

The rupture of the ligament above the patella takes place commonly in the immediate vicinity of the bone. Of 18 cases in which Binet gives the prime seat of the rupture, in 11 it was on a level with the patella, in 2 two-fifths of an inch above it, and in 5 from an inch and a half to two inches and a half above the bone. Below the patella, laceration occurs near its upper or lower insertions, and it may even carry with it some bony fragments.

The accident is most frequent in males. Middle-aged and elderly subjects are most liable to it when the ligament is involved above the patella, while rupture below the patella is almost peculiar to young persons.

The most reliable phenomena are an unnatural vacuity at the seat of the rupture, and an unusual prominence immediately above or below, inability to extend the leg, more or less pain, speedily followed by swelling, and a distinct noise heard at the moment of the accident, although the latter is by no means constant. The fact that the patella retains its integrity materially aids the diagnosis.

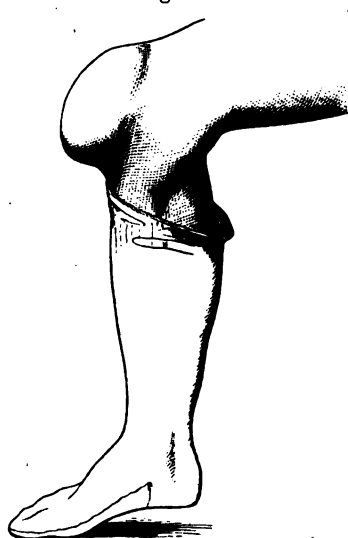
The great points in the treatment are to place the limb in an extended position upon an inclined plane, and to maintain it in a state of perfect immobility until there is complete reunion, which will seldom be under six to eight weeks. As a preliminary measure, the leg and thigh should be bandaged in opposite directions, the former from below upwards and the latter from above downwards, so as to control more effectually the action of the extensor muscle, the chief agent of the displacement. No compress is required at the seat of the injury, and care must be taken that the pressure of the bandage does not cause atrophy of the limb. Passive motion of the knee-joint should be instituted at the end of the third week, to prevent ankylosis.

In a case of ununited ligament of the patella, reported, in 1870, by Mr. John J. Hill, of New South Wales, a cure was effected by cutting down upon and paring the ends of the divided ligament, which were then kept in accurate contact by means of a long posterior splint and two leather collars, passed the one above and the other below the patella, and connected together by side straps.

HOUSEMAID'S KNEE.

An enlargement of the bursæ over the patella occasionally takes place, constituting an inconvenient and unsightly tumor, interfering with comfort and progression. It is most common in servant girls and persons who habitually exert much pressure upon this part, and is popularly known as the housemaid's knee.

Fig. 778.



Housemaid's Knee.

The immediate cause of the affection is inflammation, usually chronic, but now and then acute. The swelling is soft and fluctuating, hemispherical in shape, and unaccompanied by discoloration of the skin and enlargement of the subcutaneous veins. Some degree of soreness is usually present, but seldom any decided pain. The appearances of the parts are well shown in fig. 778, from one of my clinical cases.

Inflammation of the sac occasionally arises, generally from overexertion in walking, from frequent pressure, or from external injury, as a blow or contusion, and, if not properly treated, is liable to terminate in suppuration, attended with excessive pain, erysipelas of the skin, and more or less constitutional disturbance.

The treatment of this disease, as it ordinarily presents itself to the surgeon, consists in evacuating the contents of the sac, and injecting it immediately after with a small quantity of equal parts of tincture of iodine and alcohol, the fluid being well pushed about, and permitted to remain until it is productive of some pain. Or, instead of this, a small seton may be inserted. Excision must be avoided, as it would be likely to cause

serious trouble. The after-treatment consists of perfect repose of the parts and the ordinary antiphlogistic measures.

When a bursæ of this kind becomes inflamed, the limb should at once be placed in an easy, elevated position, and the knee, thoroughly leeches, should be wrapped up in cloths wrung out of a strong solution of acetate of lead and opium. If matter form, an early and free incision will be required.

VENOUS TUMOR.

A venous tumor sometimes occurs in front of the femoro-tibial articulation, closely resembling, at first sight, the housemaid's knee. In a case under my charge not long ago, in a man twenty-five years old, the tumor, situated directly over the patella, and about the size of an ordinary orange, was of a soft, spongy consistence, of a bluish color, free from pain, and partially effaceable under pressure. It was evidently congenital, as it was noticed soon after birth, and was composed of a mass of hypertrophied and varicose veins, a number of which were visible in the skin. There was some enlargement of the neighboring veins, but in other respects the limb was perfectly sound. The proper remedy for such an affection is subcutaneous ligation.

4. AFFECTIONS OF THE HAM.

A large *synovial bursæ* sometimes forms in the popliteal region, in connection with one of the tendons of the hamstring muscles, giving rise to a swelling which eventually seriously impedes the movements of the knee-joint. The tumor is characterized by the tardiness of its progress, by a sensation of fluctuation, or peculiar puffiness, by absence of pain, and by freedom from discoloration of the skin. If any doubt exists as to its real nature, recourse is had to the exploring needle. The treatment is by seton, by injection with iodine, or by free incision, and the insertion of a tent. No judicious surgeon excises such a tumor. In several instances in which

the operation was practised, violent erysipelas ensued, necessitating amputation of the thigh.

A *bloody tumor* occasionally arises in the ham, generally as a result of external violence, as a blow or fall, eventuating in a rupture of some of the smaller vessels in the connective tissue. It is tardy in its growth, semielastic, and productive, especially when large, of pain and stiffness of the joint. It is distinguishable from aneurism by the absence of pulsation and thrill, and by the history of the case. A section of the tumor reveals the existence of organized coagula, differing in consistence and color, some being hard and pale, others soft, almost semifluid and dark. The inclosing cyst is composed of condensed connective tissue. The proper remedy is excision.

A very curious instance, altogether unique in character, of *arterio-venous cyst*, was reported, in 1866, by Mr. C. H. Moore, of London. Formed by an expansion of the popliteal nerve, it was shaped like a double cone, and was so large as to fill the whole of the ham, its consistence being partly solid and partly fluid. An artery and a vein poured their contents into its interior, and, upon being laid open, it was found to be occupied by serum, dark clots, and loose fibrin, intermixed with clusters of white corpuscles. The diagnosis could not be determined without an exploratory incision. For a more elaborate account of this interesting case the reader is referred to the chapter on the affections of the nerves.

Solid tumors of various kinds, as the fibrous, fatty, sarcomatous, and encephaloid, are also liable to occur here, without, however, exhibiting any peculiarities requiring special notice. Their progress and consistence generally afford sufficient evidence of their true character. The encephaloid growth, especially when of rapid formation, is very liable to be mistaken for aneurism, particularly when it receives the pulsation of the popliteal artery. A number of cases have been reported, in which, in consequence of such error, the femoral artery was ligated.

Abscess of the ham is occasionally met with; generally as a result of injury, or of the extension of disease from the knee. The matter is commonly very deep-seated, and, therefore, slow in reaching the surface; the symptoms, both local and general, are unusually severe, and the fluctuation, especially in the earlier stages of the affection, is always very indistinct. The limb soon becomes stiff, the swelling is extensive, and the existence of pus is eventually indicated by an œdematous and erysipelatous state of the skin. The absence of pulsation will usually distinguish it from popliteal aneurism. Still, the surgeon must be upon his guard, not neglecting, in case of doubt, the use of the exploring needle. The proper treatment is a free and early puncture.

General Diagnosis.—Too much caution cannot be exercised in regard to the diagnosis of tumors in the popliteal region. Aneurism is of frequent occurrence here, and it should be recollected that many of its morbid growths, especially if they contain fluid, are extremely liable to pulsate, simply from their proximity to the popliteal artery. On the other hand, an aneurism, even when of large size, may exist, and yet, owing to the solidification of its contents, possess none of the ordinary signs of that disease. Numerous cases have been recorded in which an aneurism of the ham was opened under the belief that it was an abscess; where the popliteal artery was tied under the supposition that the affection was an aneurism, when it was merely an ordinary tumor; or, finally, where the thigh was amputated, the operator imagining that he had to deal with an encephaloid growth, when the dissection showed that it was nothing but a consolidated and partially cured aneurism. Desault, Pelletan, and Dupuytren were each so unfortunate as to open a popliteal aneurism, under the conviction that it was an abscess, and two instances of a similar kind have occurred in this city.

The only way to avoid such errors is to proceed with the greatest possible caution; examining the parts again and again, until we are perfectly satisfied concerning the true nature of the disease. As a general rule, the leg should be rigidly extended, when, if the case be one of abscess or cystic tumor, the swelling will usually be rendered more prominent, at the same time that it will be completely divested of pulsation, whereas, if it be aneurismal, the pulsation will be little, if at all, affected. In ordinary growths, there is always an absence of thrill and bellows sound; in aneurism, on the contrary, these symptoms are generally more or less conspicuous. In all cases of doubt, recourse should be had to the exploring needle.

5. AFFECTIONS OF THE THIGH.

The thigh is sometimes drawn remarkably inwards, in a very awkward and constrained position, by the permanent contraction of the short *adductor and pectineal muscles*. A number of cases of this kind have fallen under my observation, chiefly in young boys from five to eight years of age, without my having been able to trace the affection to any assignable cause, none of the subjects having suffered from rheumatism. The contraction sometimes exists simultaneously on both sides, and, under such circumstances, the person usually walks with great difficulty, the gait being very unseemly and crippled, the limbs during progression tending to cross each other. The remedy consists in dividing the faulty muscles freely by subcutaneous section, care being taken to keep the tenotome as closely as possible to the affected structures. The thighs should be forcibly abducted immediately after the operation, and in three or four days the patient may be permitted to run about. The cure will be expedited by exercise on the hobby-horse, and by whatever has a tendency to keep the limbs apart.

The thigh is occasionally rigidly flexed upon the pelvis by the contraction of the *straight muscle*, or of this muscle and the femoral. Such an occurrence may be the result of rheumatism, of accident, or of disease of the hip-joint, and is often readily relieved by very simple measures, as sorbefacient and anodyne liniments, the hot and cold douches, shampooing, and gradual extension of the limb. When the contraction, however, is of long standing, the only reliable remedy is the subcutaneous division of the affected muscles, an operation which is generally sufficiently simple, as it does not involve any large vessels.

The thigh, in consequence of injury or disease, sometimes stands off in a very constrained and unseemly manner from its fellow, owing chiefly, if not solely, to the inordinate contraction of the *tensor muscle*, which forms a hard, firm cord at the upper and outer part of the limb. The femoral aponeurosis often participates in the lesion, and, in that event, requires to be divided along with the tensor muscle.

In hip-joint disease, whether the result of rheumatism, accident, or tuberculosis, the attempts at rectifying the deformity of the thigh are frequently very seriously counteracted by the contraction of the *adductor and flexor muscles*, the division of which is absolutely necessary, as a preliminary measure, to success.

Among the more serious effects growing out of this faulty condition of the muscles of the thigh is permanent ankylosis of the hip-joint, the danger of which is generally in proportion to the duration of the contraction, and the consequent inactivity of the limb. It is, therefore, an object of great importance that early and efficient measures should be adopted for the relief of the parts, before the articulation has been deprived of its normal structure.

Abscesses of the thigh, often of enormous bulk, are liable to occur; they may be phlegmonous or strumous, superficial or deep, and are generally attended with great pain, swelling, and constitutional disturbance. The strumous form of the disease is most common in young subjects, from the third to the tenth year. When the matter is deep seated, it is always slow in reaching the surface, and its approach is generally denoted by an œdematous condition of the skin with a slight erysipelatous blush. A chronic abscess of the thigh, firmly bound down by aponeuroses and muscles, and attended with imperfect fluctuation, might be mistaken for an encephaloid tumor. The treatment should be by free and early evacuation of the pent-up fluid, with thorough approximation of the sides of the abscess by compress and bandage, to favor obliteration of its cavity.

Caries of the *great trochanter* sometimes takes place; it is most common in young, strumous children, and is liable to be mistaken for coxalgia. The prominent symptoms are, pain and swelling at the outer and upper part of the thigh, more or less lameness, elevation of the buttock, and constitutional disturbance. An abscess gradually forms, and, if the matter is not speedily evacuated, it may burrow extensively among the surrounding structures, causing necrosis of the trochanter, and partial destruction of the capsular ligament of the joint. The diagnosis is readily determined by a thorough examination. The diseased bone is removed with the pliers, gouge, and chisel.

Necrosis of the inferior and posterior part of the femur occasionally occurs, and is always to be dreaded on account of its proximity to the femoral artery. Long and deep sinuses are liable to form during the progress of the disease, keeping up more

or less discharge and swelling, with a tendency to ankylosis of the knee. The bone is generally affected superficially, the morbid action being confined to its outer compact structure. Sometimes the necrosed part consists of the merest shell of the shaft of the femur, hardly an inch in length by a few lines in width.

The only remedy for this disease is the extraction of the dead bone, an operation which should always be performed with the utmost care, on account of the great danger of injuring the femoral artery with the forceps, or even with the sequester itself, especially when its extremities are very sharp or spiculated. Sometimes copious, if not fatal, secondary hemorrhage arises, not, apparently, from any direct lesion to the vessel, but from an extension of the inflammation consequent upon the rude attempts at extraction. A case in which a sharp sequester pierced the popliteal artery, causing fatal hemorrhage, has been reported by Dr. Hunt, of this city.

The extirpation of *tumors* of the thigh is often attended with severe hemorrhage, especially when they are deep seated, and of large bulk, when they are not unfrequently accompanied with great enlargement of the femoral vessels. The danger will be particularly great when the main vessels of the limb are involved, or when they are thoroughly incorporated in the morbid structure. Under such circumstances, the knife, however carefully used, can hardly fail to do mischief; the artery or vein, if not both, will either be pierced, or, if they escape the point of the instrument, they may give way secondarily, in consequence of ulceration of their coats, softened during the previous disease. Hemorrhage from the femoral vein may usually be promptly checked by compression; if this fail, the vessel may be tied below the seat of the opening, or, what will be better, because more safe, a ligature may be thrown around the femoral artery. If the vein be ligated, and the blood be sent with its accustomed force and freedom along the artery, congestive inflammation will be speedily set up in the distal parts of the limb, and the patient may thus fall a prey to gangrene.

An affection of the hip, apparently of the nature of *neuralgia*, is occasionally met with, and is generally of so obscure a character as to lead to serious errors of diagnosis. I allude to the severe pain, frequently amounting to intense agony, which occurs in the hip, or hip and groin, as a consequence of endometritis. If a probe be passed into the uterus, the pain darts with the rapidity of lightning into these parts, and is followed by a sense of prostration almost equal to that produced by a severe shock of the nervous system. The disease is most common in women of a nervous, irritable temperament, and always promptly disappears on the removal of the exciting cause.

Interstitial Absorption of the Neck of the Thigh-bone.—This affection, first noticed as a distinct lesion by Mr. Benjamin Bell, of Edinburgh, in 1824, consists, as the name implies, in the gradual removal of the neck of the thigh-bone by a process of absorption, accompanied by a remarkable change in its natural conformation. It is most common in elderly subjects, but it may occur at any period of life, even as early as the third year, as in an instance recorded by Dr. Knox. The most frequent cause is external injury, as a blow or fall upon the great trochanter, eventuating in severe contusion of the osseous tissue. Violent concussion, either from direct injury, or from a fall upon the knee, may be mentioned as another exciting cause of the complaint. Sudden suppression of the cutaneous perspiration, gout, and rheumatism act in a similar manner.

The disease, however induced, is always insidious in its approaches, so much so, indeed, as to render it impossible to recognize its true character in its earlier stages. Among the more prominent symptoms at this period are dull, aching pains and a sense of weariness in the region of the hip-joint, with more or less soreness and tenderness on pressure; the movements of the limb, especially abduction and flexion, are constrained and difficult; the body is inclined forward; the thigh is bent upon the pelvis; and the patient is unable to stand erect or to bear his weight upon the affected limb without suffering. Sometimes the pains are of a sharp, neuralgic, gouty, or rheumatic character, darting down the thigh, and extending into the sacrolumbar region. In most cases, however, the pains are fixed, and particularly severe, especially at night, after exercise, and in cloudy, damp states of the atmosphere, in the region of the great trochanter. As the lesion progresses, the affected limb becomes soft and flabby, from muscular atrophy, and more or less shortened from the absorption of the neck of the thigh-bone and the alteration in its direction. These changes sometimes begin at an early period of the disease;

at other times, and more generally, they are very gradual in their occurrence, several months elapsing before they are distinctly noticeable. The amount of shortening, when the complaint is fully developed, varies, on an average, according to the stature of the individual, from one to two inches, and there is, consequently, always permanent lameness, compelling the use of a stick, if not of a crutch. The great trochanter is inordinately prominent, and stands off at an unnatural angle from the body.

The appearances of the neck of the bone are well shown in the annexed sketch, fig. 779, from a preparation in my private collection. The periosteum over the great

Fig. 779.



Interstitial Absorption of the Neck of Thigh-bone.

trochanter and lower portion of the neck of the bone is usually much thickened; the synovial membrane of the hip-joint is variously altered; the substance of the bone is frequently very porous; irregular nodules, or osseous deposits, often exist upon the margins of the acetabulum; and, in the more severe cases, the cervix is so completely absorbed that the head of the bone is brought into close contact with the great trochanter, being lodged, as it were, in a hollow in that tuberosity. The articular cartilage, and even the head of the bone itself, are often seriously involved, presenting a rough, knobby, and flattened appearance. The areolar texture is commonly rarefied. The affection, evidently, originally consists in inflammation of the osseous tissue, followed by loss of nutritive power, softening, atrophy, and change of form.

The diagnosis of interstitial absorption of the neck of the thigh-bone cannot be determined in the earlier stages of the disease. It is only after the limb has become shortened, and the trochanter unnaturally prominent, that the true character of the lesion can be detected. The affections with which it is most liable to be confounded are, fracture of the neck of the thigh-bone, ilio-femoral dislocations, and scrofulous disease of the hip-joint. From the first it may generally be readily distinguished by the absence of crepitation and shortening; from the second, by the fixed position of the limb; and from the last, by the history of the case. In fracture, except in the impacted variety, the shortening is usually immediate, and is always effaceable by extension and counter-extension. Crepitation is also generally present. In dislocation the head of the bone can usually be felt in its abnormal position; the thigh is measurably immovable, more or less rotated, and, for the most part, shortened on the occurrence of the accident. Hip-joint disease comes on gradually, and is commonly an affection of early childhood.

Unless the disease is taken in hand in its earlier stages, little is to be expected from treatment. Hence, in neglected cases, or where the diagnosis is not properly determined, permanent lameness from loss of function of the hip-joint is almost inevitable. The great remedies, for the first few months, are absolute rest in the recumbent posture, astringent and anodyne applications, leeches, iodine, and blisters. Passive motion of the hip-joint must be instituted as soon as the violence of the inflammation has abated, and the suffering structures must be well douched twice a day with hot and cold water, followed by the use of stimulating and sorbefacient embrocations. A deep issue made with the hot iron is sometimes beneficial, and I have known frequent vesication with cantharidal collodion to be of great service.

6. AFFECTIONS OF THE NATES.

Wounds of the nates require no special notice, as their treatment is generally very simple. Unless they are very deep, or complicated with lesion of the gluteal or ischiatic artery, fracture of the innominate bones, or injury of the pelvic viscera, they usually heal very kindly under simple dressing, conjoined with rest and recumbency. In the event of serious hemorrhage, the bleeding vessels must at once be

searched for, and effectually ligated at both extremities, access being, if necessary, facilitated by freely enlarging the original opening.

Abscesses, phlegmonous and chronic, occasionally form here, and, when deep-seated, may not only cause excessive suffering, but great embarrassment in regard to their diagnosis. In general, however, the history of the case, a careful examination of the parts, and the use of the exploring needle, will dispel all doubt upon the subject, and lead to the adoption of the proper treatment. If the abscess be not soon opened, its contents may burrow extensively among the neighboring structures. La Motte relates an instance in which the pus of an abscess of the buttock travelled down the limb as far as the ankle, and cases have occurred where it found an outlet through the rectum.

Aneurism of the gluteal and ischiatic arteries is extremely uncommon, and is always, or nearly always, the consequence of external injury, as a punctured, gunshot, or incised wound. The prominent symptoms are abnormal pulsation, and a peculiar whizzing, blowing, or bellows sound, easily detected by the ear. The remedy consists in exposing the sac, and ligating the artery above and below. The operation, the method of performing which is described in the chapter on aneurism, is generally a very bloody one, and demands great skill for its successful execution.

Of the various *tumors* that are liable to occur in this region the most common are the encephaloid, sarcomatous, enchondromatous, fibrous, fatty, and cystic, the latter of which is sometimes congenital. In their progress, these morbid growths may all extend into the pelvic cavity, or, originating there, they may gradually pass out at the sacrosciatic notch, and thus place themselves under cover of the gluteal muscles. Their diagnosis is generally attended with great embarrassment, and hence, if the surgeon is not fully upon his guard, very serious errors may be committed.

A unique example of congenital *fatty* tumor of the buttock, connected with the spinal membranes, through a cleft in the sacral vertebræ, has been reported by Mr. Athol Johnson, in the eighth volume of the Transactions of the Pathological Society of London. An operation was performed, and the child, who had previously suffered from convulsions from the pressure of the morbid growth on the spinal cord, was restored to perfect health.

The *congenital cystic tumor* that is liable to form here often acquires such a size as to interfere materially with the delivery of the child. Its shape is usually somewhat globular or ovoidal, its attachment being effected by a pretty broad base, extending deeply among the muscles but not into the pelvic cavity. It is soft and elastic, and fluctuates distinctly under pressure. Its contents are serous, turbid, brownish, or sanguinolent, and readily coagulable by heat, alcohol, and acids. The skin is not materially discolored, although, in general, it is a few shades darker than that in its neighborhood. The inner surface of the tumor is usually smooth and polished, and pervaded by minute, tortuous vessels with tender, friable walls. In some cases the tumor is unilocular, in others, multilocular; and instances occasionally occur in which a considerable amount of solid matter enters into its composition.

A good idea of the situation and shape of the cystic tumor of the gluteal region may be formed by a reference to fig. 780, from a drawing of a specimen formerly in the possession of Dr. Keller, who has given an account of it in the Transactions of the Pathological Society of Philadelphia. The tumor, attached to the nates, immediately behind the anus, was nearly of the size of a man's head, and, on being punctured, on the eighth day after the child's birth, it was found to contain upwards of a quart of brownish fluid. Death occurred a few hours after the operation from hemorrhage into the sac, the parietes of which were very dense, vascular, and studded internally with small, transparent cysts, filled with serum. There was no communication between the sac and the spinal canal, or the sac and pelvic viscera.

In another case, of a similar character, Dr. Keller was obliged to puncture the tumor before delivery could be effected, the quantity of fluid drawn off being about a gallon.

Fig. 780.



Congenital Cyst of the Nates.

It was also of a brownish color. The child died six hours after its birth from capillary hemorrhage into the sac, the inner surface of which was covered, in parts of its extent, by a soft tissue, exhibiting, under the microscope, a rich network of vessels, very similar to the villi of the intestine. The sac had its root between the anus and the extremity of the coccyx, somewhat to the right of the middle line, without any communication with the vertebral canal.

A tumor, evidently the result of monstrosity by inclusion, or of the presence of a blighted ovum, is occasionally found in this region, closely adherent to the sacrum or to this bone and the coccyx. It consists, for the most part, of a mass of fat, either alone or mixed with rudimentary bones, teeth, and even hair. Sometimes it contains a portion of intestine; and, in an instance observed by Dr. Richardson, a growth of this kind had an appendix attached to it, bearing a very perfect resemblance to a finger, surmounted by a well-developed nail. Dr. Spencer, of Watertown, New York, has communicated to me the particulars of a case in which the tumor was connected with the spinal cord. When the growth is merely a blighted ovum, life may be prolonged for many years.

An opinion was lately advanced that the congenital cysts in this situation have their origin frequently, if not generally, in what Luschka has described under the name of the coccygeal gland, a little reddish gray body, with a lobulated surface, from the size of a lentil to a small pea. It lies in a hollow on the top of the coccyx, between the tendons attached to that part, and has been shown by Julius Arnold to consist of clumps of small, tortuous, and dilated arteries with thickened muscular and epithelial coats. The view in question is far-fetched, and cannot be adopted without further light.

Should the child be born alive with a cystic tumor, the best plan would be to wait a few weeks, and then draw off a part of its contents, the operation being repeated every six or eight days in the hope of gradual shrinkage and ultimate obliteration of its cavity. In the event of failure, the injection of iodine might be tried, or, instead of this, the sac might be detached with the knife, particularly if it have a narrow pedicle. When the tumor is solid, and there is reason to believe that it does not include a portion of bowel, the proper method, of course, would be excision or removal with the *écraseur*.

In a case of this kind, in a child nearly nine months old, which I saw along with Dr. Eshleman and Dr. T. G. Morton, the tumor, partly soft and partly solid, occupied the sacrococcygeal region, and measured twenty-four inches in circumference by nineteen inches around its base, its size at birth equalling that of a large orange. The mass, after removal by Dr. Morton, weighed upwards of two pounds, and was found to be composed of a number of cysts, filled with serous fluid, and interspersed with granular, adipose, and fibrous matter. One of the larger cysts was occupied by a well-formed superior extremity, furnished with a thumb and fingers, and surrounded by a large quantity of waxy, sebaceous-looking matter. The tumor had very extensive connections, and during the dissection it became necessary to expose the wall of the rectum. The rectococcygeal portion, through which it had received its nourishment, was, as a matter of precaution, included in a ligature. The loss of blood did not exceed one ounce and a half. Death occurred, apparently from exhaustion, in less than twenty-four hours after the operation.

A rare case of cystic tumor of the hip, evidently caused by *hydatids*, was published in 1865, by Dr. Hendry in the British Medical Journal. The patient, a young lady of twenty-one, had suffered from weakness and occasional pain in the left hip and thigh ever since she was ten years old. The swelling, which was unaccompanied by discoloration of the skin, had latterly much increased in size, and the fluctuation was attended by a peculiar crepitation, resembling that of a bursal enlarge

Fig. 781.



Fibro-cystic Tumor of the Nates.

ment. The cyst contained upwards of a pint and a half of semiopaque fluid, of a yellowish tint, intermixed with innumerable hooklets of echinococci and minute cubic crystals of chloride of sodium and cholesterine. The disease had probably originated in the gluteal muscles.

A species of *elephantiasis*, consisting in hypertrophy and fibro-plastic degeneration of the connective tissue, is sometimes met with upon the buttocks. In a remarkable case of this kind, under my charge at the College Clinic, in 1861, in a lad twelve years and a half old, the tumor, as seen in fig. 781, formed an enormous mass hanging off both buttocks down upon the upper part of the thighs, greatly impeding progression, and causing much annoyance both by its weight, its peculiar position, and its unseemliness. It was nearly thirty inches in circumference, rounded at the extremity, and of a hard, firm consistence. Upon the surface of the tumor were two large ulcers, the seat of a copious discharge of thin, yellowish, fetid pus. The anus was dragged at least three inches beyond its natural situation, and exhibited a very irregular nodulated appearance; the perineum was hard and tumid, the scrotum was enlarged, and the penis was of extraordinary dimensions. The tumor, at its upper part, had a soft, fluctuating feel, as if the tissue around had been infiltrated with serum, as was, in fact, the case; for a very large quantity of this fluid was suddenly discharged at one of the ulcers soon after the lad fell into my hands, followed by great subsidence of the swelling.

As the general health was progressively declining, the removal of the tumor was promptly decided upon. An elliptical incision being made, so as to include the ulcerated surface, the flaps were gradually raised, but such was the intimate adhesion between the skin and the substance of the morbid growth that it was impossible to make a clean dissection. The only place where satisfactory separation could be effected was at the upper part of the tumor, previously alluded to as having been the seat of serous infiltration. Here the boundary line was well marked. The attachments were also very firm to the gluteal muscles, the fibres of which were very pale, and intimately intermingled with the abnormal structures. Several small serous cysts were opened during the operation, which was, in other respects, unattended by anything remarkable. Some large veins were noticed, but they did not bleed much, and only a few small arteries required ligation. The lad, under chloroform, bore the operation well, and made a good recovery. The tumor, after removal, weighed eight pounds, exclusively of the fluid lost during the operation. It was of a whitish color, and of dense, firm consistence, grating under the knife. Its microscopic characters, fig. 782, as ascertained by Dr. Packard, afforded a beautiful illustration of the fibrous structure, all the cells being nucleated, and most of them having more than one nucleolus.

The *synovial burse*, naturally existing upon the tuberosity of the ischium, is liable, from constant pressure and other causes, to chronic enlargement, attended with more or less pain and inconvenience, especially in sitting and riding. The tumor varies in size from a hickory nut to that of a small orange, is deep-seated, immovable, and of a globular or ovoidal shape. In its earlier stages, it imparts a peculiar vermicular sensation to the thumb and fingers, but as it increases in size it becomes soft, and distinctly fluctuates. The structures around are generally a good deal tender and indurated. When doubt exists respecting the diagnosis, the exploring needle must be used.

The treatment consists in evacuating the contents of the cyst, and then painting the skin twice a day with tincture of iodine. If the case be obstinate a small eschar may be formed upon the most prominent part of the tumor with Vienna paste; or, what is preferable, the cyst may be thoroughly divided with a delicate tenotome

FIG. 782.



Microscopic Characters of a Fibro-cystic Tumor of the Nates.

inserted subcutaneously. Temporary relief may be afforded with a hollow pad. Excision is not to be thought of, as it might prove dangerous.

7. AFFECTIONS OF THE COCCYX.

The most common causes of coccydynia, an affection originally described by Dr. Nott, are difficult and protracted parturition, attended with excessive pressure of the child's head, and various kinds of injury, as fractures and dislocations, contusions and concussions, leading to irritation, if not actual inflammation, of the osseous tissue, the periosteum, and other structures connected with the coccyx. There is a class of cases in which the suffering is, apparently, mainly dependent upon sympathy from disorder of the uterus, rectum, and urinary bladder.

The characteristic symptom of the disease is pain, generally of a dull, heavy, aching, or gnawing nature,—sometimes sharp, lancinating, darting, or shooting,—attended with exquisite tenderness of the coccyx, extending about in different directions, and liable to be aggravated by pressure, sitting, walking, and defecation, especially when there is much straining. Very frequently the suffering is greatest in the erect posture. The pain varies in degree in different cases, but it is always more or less severe, and is sure, eventually, to be followed by marked disorder of the general health, rendering life utterly miserable. In the great majority of instances it is strictly of a neuralgic character, and is then generally influenced in the degree of its severity by atmospheric vicissitudes, and by whatever has a tendency to derange the more important functions of the body. When the disease is fully established, the patient is unable to walk without great distress, and in sitting he is usually obliged to support himself upon his hip or nates. Even recumbency is often intolerable on account of the pressure of the bed upon the affected bone. The disease frequently endures for years without any material amelioration. It occurs in both sexes, but is by far most common in married women who have borne children.

The diagnosis of coccydynia is determined by the history of the case, by a careful examination of the parts, and by the absence of disease in the surrounding structures. The suffering often resembles that occasioned by anal fissure, an affection always readily discoverable with the speculum.

The milder cases of the disease occasionally yield to the use of antineuralgic remedies, especially arsenic and strychnia, either alone or aided by quinine, opiate suppositories, hypodermic injections of morphia, and change of air, with particular attention to the diet, bowels, and secretions. Constipation must always be carefully guarded against. In the more rebellious cases, the operation originally suggested by Simpson affords the best chance of relief. This consists in the subcutaneous division, by means of a narrow, long-bladed tenotome, of the muscles connected with the coccyx, so as to isolate the bone completely, first at the sides, and then at the extremity, and thus place it in a complete state of repose. The procedure, which is attended with very little hemorrhage, is generally followed by immediate and permanent relief. When it fails, the only resource is excision of the coccyx, an operation first performed by Dr. Nott in 1832, and described in the next chapter.

A small tumor, apparently of a *cystic* nature, containing hair, is sometimes met with upon the coccyx, in the vicinity of the anus, where it is likely to be mistaken for a fistule. How it originates is not clearly ascertained, but the probability is that it takes its rise in a sebaceous follicle, and that, during its development, the hair, which usually presents itself as a little tuft, is intercepted, very much as in certain sebaceous formations on the head and face. The tumor, at first hard, dense, and indolent, eventually inflames and suppurates, leaving, if left to itself, an angry, irritable ulcer, the seat of a thin, fetid discharge, more or less painful, and indisposed to heal. The parts around are red and swollen, and sometimes riddled with sinuses. The disease is more common in men than in women, and may occur at almost any period of life. The treatment consists in laying open the cyst, turning out its contents, and freely cauterizing its surface with nitrate of silver.

A rare case of congenital *fatty tumor* of the coccyx has been reported by Dr. Wilson, of England. The growth was situated over the spines of the vertebrae, in the sacral region, and presented many of the local signs of hydrorachitis, the skin over it being slightly ulcerated, and a deceptive sense of fluctuation being imparted to the fingers. In the course of four months, when it was excised, it had increased

from the size of a small egg to that of a fœtal head. It was very firmly attached to the back of the coccyx, which was turned upwards and backwards into the tumor.

8. AFFECTIONS OF THE GROIN.

Wounds of the inguinal region, whether incised, punctured, lacerated, or gunshot, may be limited to the superficial structures, or they may extend deeply among the glands and muscles, in the latter event, perhaps, dividing important vessels and nerves, and thus leading to frightful, if not fatal, hemorrhage, and other bad consequences. The treatment is generally sufficiently simple, but, in order to effect a rapid cure, it is absolutely necessary that the patient should observe strict recumbency with the thigh slightly flexed upon the pelvis, as this affords the best opportunity for the maintenance of accurate apposition of the edges of the wound. All motion of the limb must be avoided.

Any bleeding vessels are, of course, at once secured: if the iliac or femoral artery is divided, it must be tied both above and below the wound, which should, if necessary, be freely enlarged, to afford ready access to the parts. In most cases, such an injury will prove fatal before the surgeon can reach his patient. Mortification of the toes and feet is apt to follow the division of the principal artery and vein of the limb, especially if some of the anastomotic branches are involved in the mischief.

Inflammation of the groin may be common or specific; more generally the latter, the exciting cause being the syphilitic poison. The disease, in either event, may be limited to the skin and areolar tissue, or it may be located principally in the lymphatic glands, either above or below Poupart's ligament. Syphilitic bubo nearly always occupies the former situation, whereas the swelling of the lymphatic glands, consequent upon the irritation of gonorrhœa and injury of the lower extremity, generally occupies the latter, and seldom proceeds to suppuration.

In whatever manner the inflammation may have been induced, the object should be to prevent suppuration, by perfect quietude of the part, and by the application of leeches, saturnine lotions, and tincture of iodine, aided by the usual constitutional remedies. If matter form, an early and free incision, made in the direction of Poupart's ligament, is indicated. The resulting sore should be managed upon general principles, the cure being greatly expedited by laying open sinuses and enjoining recumbency.

Abscesses of the groin sometimes form in consequence of irritation in the cæcum and sigmoid flexure of the colon, the matter passing down towards Poupart's ligament, or, perhaps, even beyond it. Such collections, to which the term *stercoraceous* may very properly be applied, not only contain fecal matter, but also, at times, ingesta, bits of bones, cherry-stones, and even gall-stones, the impaction of which in the bowel is often the starting-point of the disease. However this may be, the damage inflicted upon the parts is generally so great as to lead to the establishment of irremediable sinuses and fistules.

Chronic abscesses occasionally occur here, and are always readily distinguishable by their history and progress. Great care should be taken not to confound such collections with those attendant upon psoas abscess, which, as is well known, often points in the groin, generally above, but sometimes below, Poupart's ligament, forming, in the latter event, a tumor of variable size and shape, at the upper and inner part of the thigh.

A troublesome form of *eczema* is sometimes met with in the groin, chiefly in young, fat children and elderly women, with a pendulous abdomen. The skin is chafed, red, inflamed, and the seat of a thin, watery discharge, attended with distressing itching. An occasional purge, the avoidance of stimulating food and drink, strict attention to cleanliness, and the use of Turner's cerate, or of very dilute ointment of acid nitrate of mercury, are generally the most effectual remedies.

Hypertrophy of the lymphatic glands of the groin, the result of tuberculosis or ordinary inflammation, is liable to occur, the enlarged structures forming a hard, irregular tumor, situated partly above and partly below Poupart's ligament, without any disposition, in many cases, either to advance or recede, owing, apparently, to some disorder of the general health or some local irritation. An occasional purgative and a mild course of alteratives, with the repeated application of tincture of iodine, blisters, and compression, will generally procure the gradual removal of the disease.

Angeioma of the lymphatic vessels of the groin is met with chiefly among the residents of warm countries, as the East and West Indies, South America, the Mauritius, and the Island of Bourbon. It is most common in young subjects from the seventeenth to the twenty-fifth year, and presents itself as a soft, elongated, compressible tumor, free from pain, reducible, from the volume of an almond to that of a pullet's egg, without any discoloration of the skin, and situated in the upper part of the thigh, just beneath Poupart's ligament. It consists essentially of dilated and tortuous lymphatic vessels, connected by cellular tissue, and occupied by a milky fluid, which, whenever any accidental opening occurs, often escapes in great abundance for weeks and even months. In the East Indies the affection is generally associated with chronic enlargement of the lymphatic glands, and with a discharge of chylous urine. In some cases it exists simultaneously in both groins.

No treatment is ordinarily required, except when there is a constant copious drainage of lymph, threatening impairment of the general health. In such an event, an effort might be made to obliterate the tumor by means of pins and ligatures, strangulating the enlarged vessels upon the same principle as in a *nævus*. In a case in the hands of Nélaton, the tumor was extirpated, the patient, a stout, robust young man, dying soon after the operation from pyemia.

Of *tumors* of the groin, the most common are the fatty, cystic, and fibrous, to which may be added the enlargements produced by hydrocele of the spermatic cord, varicosity of the saphenous vein, and the undescended testicle. Sarcoma, scirrhus, encephaloid, and melanosis are also occasionally observed, sometimes as primary, but more frequently as secondary, affections.

The *fatty tumor* is not always developed in the groin, but occasionally extends into it from the abdomen by a sort of migratory process. It may acquire a very considerable volume, and is generally easily distinguished by its pendulous character, and by its doughy, inelastic feel. When small and deep seated, however, it might be mistaken for femoral hernia, especially if the patient should be seized with symptoms of intestinal strangulation. The two affections, in fact, might coexist. The removal of such a tumor by the knife is usually easily effected, as it seldom adheres very closely, if, indeed, at all, to the sheath of the femoral vessels.

A *cystic tumor* sometimes occurs in the groin. It varies in size from the volume of a hen's egg to that of the fist, is of a globular or ovoidal shape, and distinctly fluctuates under the finger. Its contents are generally serous. Desault removed from the groin of a girl a hydatid tumor, for which she had previously been advised to wear a truss; and a similar case occurred to Dr. Monro, the cyst in this instance being situated at the upper and inner part of the thigh, where it might readily have been mistaken for a hernia. I have on two occasions removed morbid growths of this kind, extending deeply into the substance of the groin, and requiring caution in the dissection.

Care should be taken not to mistake for a tumor of this kind the *synovial burse* which exists between the capsule of the hip-joint, the body of the pubic bone, and the tendon of the iliac and psoas muscles, and which is liable, in consequence of inflammation, to considerable increase of bulk. The principal sign of distinction is that the enlarged pouch generally follows the movements of the thigh, whereas the cystic tumor, properly so called, usually remains stationary.

The *fibrous tumor*, which is also very uncommon, is generally easily recognized by its tardy progress, its firm consistence, and its close connection with the surrounding structures, processes often extending deeply among the vessels, nerves, and muscles. Hence, the extirpation of such a tumor is commonly attended with much difficulty.

A *hydrocele of the spermatic cord* occasionally projects into the groin, forming a tumor of variable size and shape, but usually easily recognized by its softness, elasticity, and fluctuation, by its tardy progress, by the absence of disease of the skin, and by the unimpaired state of the general health. If any doubt exist in regard to the diagnosis of the case, recourse is had to the exploring needle.

A tumor, of considerable size, is sometimes formed by *varix of the saphenous vein* at its junction with the great femoral. The enlargement, which is most frequently met with in old, fat subjects, in connection with similar disease of the leg, is commonly of an oblong shape, soft, and about the size of a large almond. It does not receive any impulse on coughing, and is readily effaced by pressure upon the upper part of the saphenous vein, but promptly reappears when the pressure is removed.

An undescended *testicle* is sometimes retained in the groin, forming a tumor which, especially if inflamed, might lead to the suspicion of the existence of hernia. The absence, however, of the organ from the scrotum, and the peculiar hardness of the inguinal tumor, together with the sickening sensation caused by compressing it, will always serve to distinguish it from all other affections.

Scirrhus of the groin generally takes its rise in the lymphatic glands, for the most part as a secondary affection consequent upon malignant disease of the thigh, penis, testicle, or vulva. As an original malady, its character is seldom detected in time to admit of operative interference, as the lymphatic glands in the iliac region usually soon participate in the morbid action, and thus oppose an effectual barrier to the use of the knife.

Encephaloid of the groin is occasionally witnessed, as in a very remarkable case which came under my notice, in a young lady, twenty years of age. The disease had, apparently, commenced in the lymphatic glands, when she was sixteen, and gradually progressed until, several months before she expired, it involved the entire circumference of the upper part of the thigh and nearly the whole of the corresponding natis, forming an enormous mass, attended with excessive emaciation and great enlargement of the subcutaneous veins, some of which were almost the size of the little finger. A few weeks before dissolution, the tumor gave way at its summit, throwing out a large, bleeding fungus.

In another case of this kind the morbid growth occupied the groin, the inner part of the thigh, and the perineum—to the latter of which it was attached by a broad base—the patient being a man, thirty-six years of age, who had always enjoyed good health until about five months previously. The tumor, which was fully the size of a child's head at birth, was remarkably tuberculated on the surface, of a soft, spongoid consistence, and the seat of a most copious, fetid discharge. A few days before I saw it, it had given way by ulceration, and bled very profusely. The glands of the groin were extensively implicated in the disease, and several of them—the largest the size of a pullet's egg—were completely denuded, standing out prominently upon the upper part of the thigh. The tumor, which interfered greatly with defecation, soon proved fatal.

Melanosis of the groin generally begins in the superficial lymphatic glands and is almost invariably associated with similar disease in other parts of the body. It is easily distinguished, even in its earlier stages, by its black color, its firm consistence, and its tuberiform shape. Death usually occurs at a period varying from six to twelve months, secondary tumors in the mean time showing themselves in different regions of the body.

General Diagnosis.—The surgeon, in contemplating the diseases of the groin, will not lose sight of the fact that he has to deal with a region which is often the seat of hernia, both inguinal and femoral, of psoas abscess, and of aneurism, the latter formed either in the course of the femoral artery or in that of the external iliac. He will, therefore, be slow in making out his diagnosis, and particularly wary in the employment of the knife. He will not forget, on the one hand, that a tumor not aneurismal may, if situated over the track of the femoral or iliac artery, readily receive an impulse from the vessel, so as to lead to a false suspicion regarding its true character; nor, on the other, that an aneurism may actually exist, and yet be free from pulsation, or, perhaps, be even so soft as to simulate an abscess, especially if it be accompanied with considerable œdema and discoloration of the skin. The great danger of mistake, however, generally arises, not from tumors, but from hernia, which often coexists with various kinds of swellings of the groin, inflammatory and other, and which, in the event of the supervention of symptoms of intestinal strangulation, might, therefore, occasion great embarrassment, both in regard to the diagnosis of the case, and the proper course of treatment to be adopted for its relief. The opening of an abscess of the groin overlying a knuckle of small intestine, has been followed more than once by an incurable fistule. How cautious, then, should the surgeon be in the employment of his knife in a region of such vast importance to health and life!

9. ANCHYLOSIS OF THE HIP-JOINT.

Anchylolysis of the hip-joint may be produced by various causes, as external injury, rheumatism, gout, syphilis, and coxalgia, or tubercular disease. Mere contraction

of the femoral and gluteal muscles not unfrequently occasions serious impediment in the functions of the articulation, independently of any structural changes. The rigidity, however induced, presents itself in various degrees, from the slightest impairment of motion to the complete consolidation of the contiguous surfaces by osseous matter. The manner in which the thigh inclines in ankylosis of the hip-joint is far from being uniform, but, in most cases, it is directed inwards, and flexed more or less strongly upon the pelvis, the leg being at the same time bent upon the thigh, and the foot raised from the ground. The cases in which the limb is turned out are comparatively rare, and are met with chiefly in connection with partial or complete destruction of the brim of the acetabulum and of the head and neck of the femur, either as a result of injury or disease. Sometimes the limb stands off horizontally, at a right angle with the pelvis.

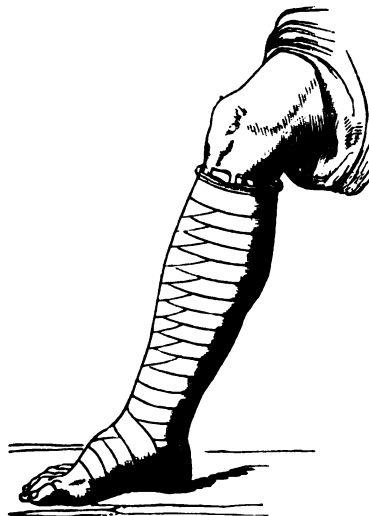
Ankylosis of this joint cannot exist, even in a comparatively slight degree, or for any length of time, without being followed by more or less distortion of the pelvis and loins, in the form of compensating curves; the muscles of the thigh and leg become wasted and rigid; and the knee is eventually rendered stiff and useless. The true condition of the articulation can seldom be satisfactorily determined without the aid of an anæsthetic.

The treatment, in recent ankylosis, consists in breaking up any adhesions that may exist by moving the thigh forcibly upon the pelvis, and then rectifying the position of the limb by appropriate apparatus. Passive motion should be instituted from time to time, and extension, if necessary, maintained by means of a weight attached to the leg, as in the treatment of fractures of the lower extremity. Any muscles that act interferingly should be divided with the tenotome, and it is surprising how much such a procedure generally expedites the cure. When the articular surfaces are completely soldered together by osseous matter, and the ordinary means of relief are unavailing, an attempt should be made to sever the connection by the subcutaneous employment of the gimlet and other means, detailed in the chapter on diseases of the joints; or, if this be inapplicable, by the subcutaneous section of the neck of the bone, as practised by Mr. Adams, of London.

10. BANDAGES FOR THE INFERIOR EXTREMITY.

The ordinary roller for the foot and leg is represented in fig. 783. It will be seen that its application begins at the toes, and that it is continued, by circular and

Fig. 783.



Roller Applied to the Foot and Leg.

reversed turns, as high up as the knee. Its usual length is from five to six yards; its width from two inches and a quarter to two inches and a half. A roller, of similar length and width, will answer for the thigh, the connection being uninterrupted. Care is taken not to make the reverses over the shin, lest they should provoke ulceration. Particular care is also necessary in conducting the bandage across the ankle and knee. In general, compresses will be required to fill up the vacuities between the tendo Achillis and the malleolar processes.

For retaining dressings on the knee, as in inflammation and wounds of the joint, an ordinary roller may be used; or, what is more neat and convenient, a piece of muslin, from eight to ten inches in width, and about a yard and a quarter in length, the extremities of which are split to within a short distance of its centre. The latter is then applied to the patella, and the ends, crossed behind the ham, and tied, respectively above and below the knee, as exhibited in fig. 784. In dropsy and loose bodies of this joint, a special contrivance, called a laced knee-cap, described in the first volume, is sometimes employed.

Bandages for the groin are rendered necessary in the treatment of various affections, as buboes, abscesses, and wounds, and also after the operation for strangulated

hernia and the ligation of the external iliac artery. A very effective contrivance of the kind is a triangular piece of muslin, passed around the thigh, the base being fastened in front, and the apex behind, to a band encircling the abdomen, additional security being given by a side strip, as seen in fig. 785.

Fig. 784.



Bandage for the Knee.

Fig. 785.

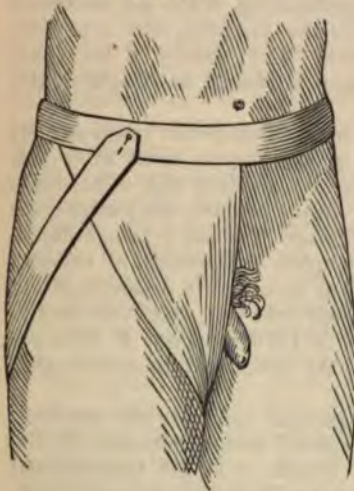


Fig. 786.



Bandages of the Groin.

Occasionally the bandage, depicted in fig. 786, may be advantageously employed. It consists of an ordinary roller, from six to eight yards in length by two inches and a half in width, which is carried around the abdomen and the upper part of the thigh, by circular and reversed turns, until the object for which it is applied has been attained. In most cases, it will be best to extend it around both limbs, as it will thus be less likely to slip and become useless. The spica bandage for the groin and thigh is now seldom employed.

CHAPTER XXI.

SPECIAL EXCISIONS OF THE BONES AND JOINTS.

1. TRUNK.

EXCISION OF THE CLAVICLE.

EXTIRPATION of this bone may be required on account of caries, necrosis, morbid growths, and displacement in consequence of disease. Mr. Davie, of Bungay, many years ago, excised the inner extremity of the clavicle in a case of dislocation backwards from deformity of the spine, the luxated head causing such a degree of pressure upon the œsophagus as to endanger life by inanition. Having made an incision

from two to three inches in length over the bone, in a line with its axis, and severed its ligamentous connections with the sternum, he divided the bone about one inch from its articular end, by means of a Hey's saw, the soft parts being protected by a piece of sole-leather. The patient speedily recovered, and survived the operation six years. In my private collection is nearly the whole of the left clavicle, which I removed, in 1849, on account of necrosis, from a lad thirteen years old. In 1813, Dr. Charles McCreary, of Kentucky, excised the right collar-bone at its articulations for scrofulous caries: the patient, a boy of fourteen, survived the operation many years, with an excellent use of the corresponding limb. A similar operation was successfully performed in 1852 by Dr. A. J. Wedderburn, of New Orleans, in 1856 by Professor Blackman, of Cincinnati, and in 1860 by Dr. Fuqua, of Richmond. In the latter case, however, the sternal end of the bone was saved.

In 1828, Dr. Mott removed the entire clavicle, on the left side, on account of an osteo-sarcomatous tumor, of great hardness, conical in its shape, and four inches in diameter at its base. The operation was one of immense delicacy and difficulty, requiring nearly four hours for its execution, and more than forty ligatures for the suppression of the hemorrhage. The patient, notwithstanding, made an excellent recovery, and, by means of an apparatus contrived for the purpose, had a perfect use of the arm, being able to move it in all directions. The history of the case, with a detail of the different steps of the operation, may be found at length in the *American Journal of the Medical Sciences* for 1828.

Dr. J. C. Warren, in 1832, removed the clavicle of a man, twenty-four years of age, also on account of osteo-sarcoma. Death occurred in the fourth week after the operation. Mr. Travers, of London, in 1837, successfully excised the collar-bone for a cystic hematoid tumor in a lad ten years of age. More recently the entire bone was excised, for a similar disease, by Dr. Curtis, of Chicago, Professor Langenbeck, of Berlin, and Dr. Cooper, of California. The first complete extirpation of the clavicle was performed, in 1732, by Remmer. The bone was involved in a sarcomatous growth weighing five pounds. A few years ago the clavicle was removed by Dr. James C. Palmer, on account of gunshot injury; and in 1870 Dr. Paul F. Eve excised the entire bone affected with enchondroma. All the cases had an unfavorable termination, either primarily or secondarily.

It is obviously impossible to lay down any definite general rules for the resection of this bone. When its removal is required on account of caries, necrosis, or displacement from disease, the operation is sufficiently simple, a single longitudinal incision, in the axis of the bone, affording ample space for its isolation and detachment. But the case is widely different when the clavicle is buried in a large mass of disease; when the circumjacent structures are all intimately matted together by morbid deposits; and when not only the great vessels of the neck, but likewise the phrenic nerve and the thoracic duct, are in close proximity to the affected bone, as in the instance of Dr. Mott. Under such circumstances, the operation is one of extraordinary difficulty, demanding the greatest patience, skill, and anatomical knowledge for its successful execution. The surgeon must proceed with the greatest circumspection, making constant use of the handle of the knife, keeping in close contact with the tumor, tying the arteries as they are divided, and guarding against the entrance of air into the veins, the danger of which is always considerable in the excision of morbid growths at the base of the lower cervical region. Trustworthy assistants must be at hand, and every emergency must be anticipated.

EXCISION OF THE SCAPULA.

Excision of this bone has now been so frequently performed as not only to establish its feasibility, but to prove that, when the cases are properly selected, it is comparatively devoid of risk. The cases of Mussey, Rigaud, Fergusson, Schuh, myself, and others, in some of which the entire scapula was removed along with a considerable portion of the clavicle, clearly evince what the human body is capable of enduring under dissections of a character apparently the most desperate. Dr. Mussey's operation was performed in 1837; the patient, six years after the arm had been amputated at the glenoid cavity, had an osteo-sarcoma of the scapula and clavicle, both of which were removed in their whole extent. The enormous wound healed almost completely by the first intention, and the man, when last heard from, fifteen years after the operation, was still well. In 1844, Rigaud, of Strasburg, took away,

with complete success, the entire scapula, with the external extremity of the clavicle, on account of an osseous growth, from a man 51 years of age, whose arm had been amputated at the shoulder-joint eight months previously. Dr. Victor von Bruns, in 1853, excised the whole of the scapula, excepting the extremities of the acromion and coracoid processes; and Langenbeck, two years later, took out the entire bone, preserving the corresponding limb. Professor Schuh, of Vienna, removed nearly the whole shoulder-blade in 1860, on account of osteo-sarcoma, in a child eight years of age. A case of successful extirpation of the entire bone along with the acromial end of the clavicle, with preservation of the arm, in a girl eighteen years of age, is related by Dr. Hammer, in the St. Louis Medical Reporter for 1856. A similar operation was performed in 1867 by Dr. Stephen Rogers, of New York, on account of carcinoma in a child, a little upwards of seven years of age. In both these cases the excision was effected at two periods; in the former after a lapse of a few days, in the latter of a few months. In October, 1868, Mr. Sidney Jones, of St. Thomas's Hospital, London, excised the entire scapula, excepting the acromion process, for an enchondroma, weighing nearly eleven pounds. His patient, a man, thirty-three years old, died on the fourth day. Dr. Schuppert, of New Orleans, in 1868, removed successfully the whole of this bone from a woman thirty-six years old, the subject of three previous operations, on account of an osteo-chondroma, weighing nearly six pounds. Hammer, in 1869, and Steele, in 1871, each extirpated the entire bone, with a fatal result, for carcinoma. Michaux, in 1864, extirpated the entire bone for encephaloid tumor, the patient dying ten months after from a return of the disease.

If it be impossible to lay down any specific rules for the performance of excision of the clavicle, it would be still more futile to attempt such an undertaking for the scapula. The truth is, every case must provide its own rules. The following instance, in which, in 1850, I removed nearly the whole of the right scapula for an osteo-sarcomatous affection, will serve to convey a general idea of the procedure necessary under such circumstances. The patient was a man, forty years of age, and the tumor, first noticed nine years previously, was fifteen inches in length by fifteen and a half in width at its widest part.

The patient being placed recumbent, with the body inclining towards the abdomen, an incision, sixteen inches in length, was made from the superior angle of the scapula to the inferior extremity of the tumor, its direction being obliquely downwards and inwards. Another, beginning about five inches below the upper end of the first, and terminating about the same distance from its lower end, was then carried, in a curvilinear direction, so as to include a small oval flap of the skin in its centre. The integument, which was exceedingly dense and thick, especially at the superior part of the tumor, was then dissected off from the surface of the morbid growth, first towards the spine, and then towards the axilla. Having detached the elevator and trapezius muscles, I sawed through the acromion process of the scapula immediately behind the clavicle, and then divided the broad dorsal and anterior serrated muscles. Carrying my fingers underneath the tumor, and raising it up, I severed its connections with the ribs, cut the deltoid and other muscles of the arm, sawed the neck of the scapula, and thus removed the entire mass with comparatively little difficulty.

Several vessels were divided in the early stage of the operation, at the posterior and middle part of the tumor; but these were easily controlled by the fingers of the assistants. Several arteries near the neck of the bone bled so freely as to demand the ligature after the removal of the morbid growth. About twenty-four ounces of blood were lost. The patient became very faint towards the close of the operation, and cordials were necessary to revive him. The immense wound thus produced was dressed with three interrupted sutures and adhesive strips, and supported by a compress and a broad body bandage.

No untoward symptoms occurred after the operation; nearly the whole wound healed by the first intention; and, at the end of three weeks, the patient went home, gradually improving in health and strength. From exposure to cold, however, he contracted pleuro-pneumonia, from the effects of which he died three months after the operation. The neck and glenoid cavity of the scapula were unaltered, but the remainder of the bone was completely disorganized. The tumor weighed upwards of seven pounds, and belonged to that class of structures usually denominated osteo-sarcomatous. The external appearances of the tumor are exhibited in fig. 787.

Fig. 787.



Osteo-sarcoma of the Scapula.

The entire scapula has occasionally been removed on account of necrosis or long-standing caries. Such an operation was first performed in 1847 by Sir William Fergusson, by Mr. Syme in 1856, and in 1858 by Mr. G. M. Jones, the disarticulation in the two latter instances being effected at the shoulder-joint, with removal of the acromial extremity of the clavicle. All the patients recovered with a good use of the corresponding limb.

I have on two occasions removed nearly the whole of the spine of the scapula for necrosis; and a considerable number of cases have been recorded of excision of the acromion process. The coracoid process has also been extirpated both on account of injury and disease.

The statistics of excision of the scapula are highly flattering. Of 56 cases, analyzed by Dr. Stephen Rogers, of New York, including one by himself, in 25, or nearly fifty per cent., at least three-fourths of the bone were removed, with an excellent use of the corresponding arm in 16. From the facts developed in this table, it appears that extirpation of the entire scapula, either alone or along with a portion of the clavicle, is not attended with any greater danger than extirpation of one-half, two-

thirds, three-fourths, or four-fifths of the bone. Of 45 cases of partial excision, 10 died of causes more or less directly connected with the operation, as shock, loss of blood, air in the veins, pyemia, or exhausting suppuration, making a total of one in four and a half. On the other hand, not a single patient perished from the effects of excision of the entire bone.

EXCISION OF THE RIBS.

Caries and necrosis of the ribs, both from disease and accident, are by no means uncommon, and often lead to the necessity of excision. These pieces are also liable to carcinomatous degeneration, and to different morbid growths, which can only be removed by the interposition of the knife and pliers. The annals of surgery afford numerous examples of excision of the ribs, from a portion hardly an inch in length to nearly the entire bone. Operations of this kind were probably performed at a very early period of the profession, and some very extraordinary cases have occasionally been published of their success. Thus, it is reported of Suif that he cut away from a man two of his ribs, making an opening into his chest capable of admitting the fist, and through which he removed, with complete success, a portion of diseased lung. Incredible as this case may at first appear, it has its analogue in one which occurred in the practice of Dr. Milton Antony, of Georgia. In this instance, the fifth and sixth ribs, which were extensively carious, were removed along with two-thirds of the right lobe of the lung, the patient surviving the exploit nearly four months. The particulars of this remarkable case are recorded in the sixth volume of the Philadelphia Journal of the Medical and Physical Sciences. I have repeatedly excised considerable portions both of the ribs and of their cartilages; and at the College Clinic in 1857, I removed from a negro lad, seventeen years of age, the central pieces of the sixth and seventh ribs, one of which was upwards of six inches in length, on account of scrofulous disease. During the operation, the apex of the heart could be plainly seen pulsating beneath the denuded structures. The boy rapidly recovered, and has ever since been in good health. Formidable operations upon the ribs, affected with various kinds of tumors, for the most part of a carcinomatous character, have been performed by different American surgeons, among whom it will be sufficient to mention the names of John C. Warren, George McClellan, and William Gibson.

In caries and necrosis of the ribs, excision may be performed with the greatest facility, as the diseased pieces are always more or less isolated by the morbid action, especially from the pleura, which is usually very much thickened and indurated,

and, therefore, not at all in danger of being injured, unless great negligence is displayed. The intercostal arteries, too, are generally out of harm's way. In necrosis, a slight incision will commonly suffice to enable the surgeon to effect extraction, but in caries a more extensive incision, made in the axis of the affected bone, will be needed. If the attachments are firm, the knife must be kept close to the bone, and it is safer here, as elsewhere, in similar cases, to use the handle of the instrument than its point. When the ribs are involved in morbid growths, excision will be environed with many difficulties, owing to the fact that the pleura generally retains its normal characters, and that it is then almost impossible to separate it from the affected structures without penetrating its cavity; moreover, such tumors are usually extremely vascular, and are apt to project to a considerable distance beneath the surrounding parts. As it respects the incisions necessary in such cases, the most eligible and convenient will be the T-shaped, semilunar, or elliptical.

EXCISION OF THE STERNUM AND ENSIFORM CARTILAGE.

The sternum has occasionally been excised, not wholly, of course, but in part, on account of caries, to which its substance is very subject in scrofulous and syphilitic persons, and also on account of necrosis, gunshot injury, and compound fractures. Its affections are liable to be complicated with abscess in the anterior mediastinum, thickening of the pleura, and lesion of the costal cartilages. The diseased portions may usually be gouged away or extracted without difficulty, exposure having been effected by a T-shaped or crucial incision. When the bone is largely implicated, without any tendency to spontaneous separation, the removal will be expedited by perforating it with the trephine, to admit the introduction of the elevator. In general, however, its substance is so soft that it may easily be cut away with the pliers, or even a stout, probe-pointed knife.

The ensiform cartilage was excised by Odoardo Linoli, in 1852, in a man, twenty-two years of age, on account of severe suffering, habitually experienced after eating from the pressure of this body upon the stomach. The cartilage was bent inwards, and, when firmly pressed upon, immediately gave rise to gastric distress. During recumbency no inconvenience was felt, but the erect posture almost invariably caused gastralgia and even, at times, more or less vomiting after a hearty meal. The operation perfectly relieved the distressing symptoms.

EXCISION OF THE PELVIC BONES.

The bones of the pelvis are liable to caries and necrosis, often attended with troublesome sinuses, and sometimes requiring extensive operative interference. I have, in one instance, been compelled to remove the tuberosity of the ischium; in another, a large fragment of the iliac crest; and, on one occasion, a considerable piece of the posterior and lateral part of the sacrum. Exostoses sometimes form upon these bones, and may, unless deeply seated under the gluteal muscles, be easily removed with the knife and chisel.

The coccyx may be invaded by caries, from the contact of fecal matter in anal fistule; and a similar effect is occasionally produced by a blow or kick, or by injury inflicted by the pressure of the child's head in protracted parturition. Dr. Nott, as early as 1832, excised this bone on account of severe and intractable neuralgia seated in its substance, its lower extremity being hollowed out into a mere shell. A vertical incision was made behind, along the middle line, when the bone was disarticulated at the second joint, and separated from its muscular and ligamentous attachments. The patient was a female, twenty-five years of age; the wound was long in healing, and a month elapsed before the pains disappeared from their original site. Dr. Nott has since repeated this operation several times, and it has also been performed, with variable success, by Simpson, Godfrey, and others, on account of a similar disease.

2. SUPERIOR EXTREMITY.

EXCISION OF THE BONES OF THE HAND.

Excision of the head of the phalanx of the thumb has sometimes been practised in compound dislocations and fractures, and the success attending the operation has

afforded a warrant for performing it in case of caries of its substance. The joint is exposed by a free lateral incision, and the offending portion removed with the pliers. The cure will be more likely to be satisfactory if a small piece be clipped off from the contiguous bone, as the two raw surfaces, when brought together, will then unite more readily.

It is never desirable to exsect any of the *digital phalanges*, except the distal one; such a procedure would only leave a useless finger, and could, therefore, never become general. When the last phalanx is rendered carious, or deprived of its vitality, as so often happens in whitlow, the proper plan is to remove it through an incision extended along its palmar aspect; and it is well known that, when the periosteum is not destroyed, the bone, under these circumstances, is sometimes partially regenerated.

Excision of all the *carpal bones* has occasionally been attempted, generally in connection with that of the articulating extremities of the radius and ulna, but I am not aware that it has ever, in a single case, been followed by any satisfactory results. On the contrary, the disease for which the operation was performed has nearly always returned, and eventually led to the necessity of amputation of the forearm. It is questionable, therefore, whether the operation is worthy of repetition. It is different, however, when only a few of the carpal bones are in a carious state; then excision of the affected pieces should be practised by all means, for if pains be taken to remove all the morbid structure, and no serious injury is inflicted upon the soft parts, particularly the sheaths of the tendons, there will be a very reasonable prospect of a good result, the hand not only preserving its usefulness, but also its symmetry. In several cases in which I adopted this method the result was most satisfactory. In an instance in the care of Mr. Butcher, of Dublin, the magnum, cuneiform, trapezoid, and unciform bones, together with a part of the lunar, and two-thirds of the fourth and fifth metacarpal bones, were excised, and yet a very useful hand was left. The site of the piece to be removed will usually be indicated by a fistulous opening; if any formal incision is necessary, it should be made upon the dorsal surface of the hand. A gouge and mallet will be indispensable instruments in the operation.

The *metacarpal bones* have frequently been removed in part, or in whole, for caries, necrosis, or external injury. The operation, which is sufficiently simple, consists in making a longitudinal incision along the dorsal aspect of the bone, in separating it from the soft parts by keeping the knife close against its surface, and in disarticulating it in the usual way. The carpal end of the bone, if sound, should be left, and in that case the division should be effected with the pliers. As the object is to preserve the finger, the extensor tendon is carefully drawn aside during the operation. The metacarpal bone of the thumb may be treated in a similar manner, the phalanges being retained; and, although the member may not, for a time, be of any material use, yet as the soft parts become consolidated it will be found to be very serviceable, to say nothing of the important part which it plays in preserving the symmetry of the hand. In 1858 I removed the metacarpal bone of the right index finger for a gentleman, thirty-three years of age, on account of a gunshot injury, leaving the tendons of the extensor and flexor muscles intact, and the consequence was a most excellent state of the finger.

EXCISION OF THE WRIST-JOINT.

Excision of the wrist-joint, originally performed by Mr. Cooper, of England, soon after the middle of the last century, has been practised much less frequently than that of the other articulations, and in the cases in which it has been done the result has not been at all encouraging. The operation, besides being awkward and difficult on account of the importance of the structures concerned in it, and the peculiar conformation of the joint, is extremely liable to be followed by permanent ankylosis of the wrist, and stiffness of the fingers. Another objection is that, when the carpal bones are involved in the disease, there is apt to be a return of the morbid action, eventually necessitating amputation of the forearm. Hence some surgeons prefer amputation in the first instance to the risk, pain, and inconvenience of excision without the certainty of a final cure. In opposition, however, to this decision, it may be urged that a stiff hand with the preservation of the mobility of even some of the fingers is very greatly to be preferred to no hand at all, both on the score of

utility and seemliness, and that there are few persons who, if the matter were left to their own choice, would not rather submit to excision, if it afforded any reasonable prospect of success, than to the unconditional loss of so important and valuable a member.

There are two methods according to which this operation may be practised; in one the incisions are made along the inner and outer margins of the limb, in the other over its dorsal aspect, in the form of a semilunar flap, with the convexity downwards. When the disease necessitating the operation is limited to the ulna and radius, the former plan is to be preferred, but the latter, as affording more room, when the carpal bones participate in the disorganization. Whichever procedure be adopted, care is taken not to divide the extensor tendons of the thumb and fingers, as this would compromise their future usefulness, and thus frustrate the main object of the excision. The ends of the radius and ulna are removed on the same level, either with the pliers or with a narrow saw; in the flap operation it may be necessary, during the division of the bones, to protect the soft parts with a spatula or a strip of leather.

During the after-treatment, the forearm, bent nearly at a right angle with the arm, is well supported with two light splints, and the thumb and fingers are kept semi-flexed, in order that, when the cure is completed, they may be more easily approximated. Passive motion may be instituted at the end of a few weeks.

The statistics of this operation are very limited. The tables of Dr. Hodges contain 39 cases of excision for disease, of which 17 recovered, the majority of them having a more or less serviceable hand; 6 died, 8 underwent subsequent amputation, and in 8 the result was undetermined. The mortality after amputation of the forearm is only a little over 12 per cent. Excision of the wrist-joint for gunshot wounds, as indicated by the tables of Dr. S. W. Gross, has been practised 43 times, with 36 recoveries and 7 deaths, the mortality rate being 16.28 per cent.

EXCISION OF THE BONES OF THE FOREARM.

The bones of the forearm may require extirpation in part, or in whole, for caries, gunshot injury, or chronic enlargement. Dr. Compton, of New Orleans, in 1853, excised both the radius and ulna, except the inferior extremity of the former, on account of a compound, comminuted fracture, two months after the accident. The greater portion of the periosteum, detached during the progress of the resulting inflammation, was left in the wound. The patient, a boy, fifteen years of age, made an excellent recovery, with a very good use of the hand. The forearm was three inches shorter than natural, and flexed at a right angle with the humerus.

Dr. Robert B. Butt, of Virginia, in 1825, exsected the lower two-thirds of the *ulna* of the left side, in a man twenty-five years old, who, several years previously, had received a punctured wound in the wrist-joint, causing violent inflammation of the whole limb as far as the elbow, and ultimately terminating in hypertrophy and caries of the *ulna*, with immense thickening of the periosteum. Three months after the operation, the man had so far recovered as to be able to pursue his occupation of a house-joiner, flexion, extension, and rotation of the joints being as free and uninterrupted as they had ever been. In 1853 Dr. Carnochan performed a similar operation, taking out the entire *ulna*, which, as in the case of Dr. Butt, was excessively enlarged from one extremity to the other, measuring, at the base of the coracoid process, five inches and a half in circumference, and weighing nearly eight ounces. His patient, a man, thirty years of age, was of a strumous habit, and the disease was supposed to have been occasioned by a severe sprain of the arm. No untoward symptoms occurred during the after-treatment; very little deformity was perceptible when the wound was healed; and the functions of the hand and forearm were preserved in a remarkable degree. Mr. Jones, of Jersey, has also removed the whole *ulna*; and Dr. George Williamson, in his Notes on the Wounded from the Mutiny in India, refers to a similar case in which, on account of disease, he exsected this bone along with the head and neck of the radius, and the lower end of the humerus, the patient regaining an excellent use of his limb. Dr. C. S. Muscroft, of Cincinnati, exsected the entire *ulna* successfully, in 1870, on account of caries, in a man forty-two years old.

The entire *radius* was exsected by Dr. Carnochan, in 1854, on account of caries, hypertrophy, and eburnation, caused by a blow upon the upper part of the

forearm, the patient, a man, twenty years old, recovering with such an excellent use of the limb as to be able to write with ease and rapidity. When last seen, six years after the operation, the parts remained perfectly sound, but the hand was not quite in its natural axis, as it inclined a little outwards, while the styloid process of the ulna formed an abnormal prominence on the inside of the wrist. The bone was excised from joint to joint. An operation of a similar kind, with an equally fortunate result, was performed in 1859 by Dr. Choppin, of New Orleans, upon a boy, fourteen years of age. In this case, however, the inferior articular extremity of the bone was retained, as it was found to be free from disease.

In 1857 I excised, at the College Clinic, somewhat more than the upper half of the bone, along with the outer condyle of the humerus, for scrofulous disease of several years' standing, the patient being a young man in dilapidated health. He recovered well from the operation, but of the ultimate result I am unable to give any account, as the case was soon after lost sight of. The appearance of the limb, prior to the operation, is exhibited in fig. 788.

Fig. 788.



Caries of the Elbow-joint, as seen before Excision.

Mr. Erichsen states that he has resected the whole radius, with the exception of its articular head, which was sound, and that a useful arm was left. Excision of the lower four-fifths of this bone was performed by Dr. Carnochan, in 1857. His patient, a woman, thirty-one years of age, made an excellent recovery, the functions of the hand being so little impaired that she was able to perform her household duties nearly as well as before the operation. The bone was greatly diseased and enlarged.

Excision of the entire radius is performed by making a longitudinal incision along the posterior and outer aspect of the forearm, from the wrist to the elbow, and in detaching the bone carefully from its connections, with the precaution of inflicting as little injury as possible upon the surrounding structures. In caries, the bone is occasionally so slightly adherent that the periosteum may readily be peeled off from it by means of the handle of the knife, as happened in my case of partial excision. When the attachment is very firm, the rule is to keep the knife as closely against the bone as possible. Removal of the ulna is effected upon the same principle, but in this case the incision is carried along the posterior and inner aspect of the limb. In neither operation is it necessary to divide any of the principal arteries of the forearm, and hemorrhage from the smaller branches may be moderated by compression of the brachial by the fingers of an assistant. When the entire ulna or radius is removed, the proceeding will be facilitated by giving the wound, at each extremity, a curvilinear direction, or a short transverse cut may be extended from it at these points, either outwards or inwards, according to the nature of the bone concerned.

Excision of portions of the bones of the forearm has been practised for *gunshot injuries*, with very encouraging results. Of 237 cases, tabulated by Dr. S. W. Gross, 252 recovered, and 35 died, the ratio of mortality being 12.19 per cent. Both bones were the seat of the procedure 29 times, of which 5, or 17.24 per cent., were fatal; the radius was excised in 130 cases, with 13 deaths, a ratio of mortality of 10 per cent.; and the ulna was excised 128 times, with 17 deaths, or a mortality of 13.28 per cent. Seven of these cases required consecutive amputation.

EXCISION OF THE OLECRANON.

Excision of the olecranon may be required for caries, or caries and necrosis. The operation is also occasionally demanded on account of gunshot and other injuries. A longitudinal incision being made over the posterior part of the elbow, the process is detached from the tendon of the extensor muscle, and divided with the pliers or a narrow saw. The wound is accurately approximated by suture, plaster, and collodion, the limb is maintained at rest in the straight position, and, in due time, passive motion is instituted, to preserve the use of the joint.

Dr. Gurdon Buck, in 1842, excised the olecranon on account of hypertrophy of its substance from external injury, followed by total loss of flexion and extension, although pronation and supination partially remained. The patient recovered from the effects of the operation, but the limb, instead of being benefited, became permanently stiff.

EXCISION OF THE ELBOW-JOINT.

Excision of the elbow-joint has been so frequently practised, and the success attending it has been so flattering, that it is now universally accepted as one of the established operations in surgery. Complete excision was first performed by the elder Moreau, in 1794. Wainman, of Shripton, England, had sawed off the lower end of the humerus, in a case of compound dislocation, in 1758; and, in 1775, Justamond, of London, cut away the olecranon and two inches of the ulna for disease. The younger Moreau repeated the operation in 1797, after which it fell into desuetude in France until it was revived, in 1819, by Roux, who became one of its warmest advocates. In England, the elbow was first completely excised by Stansfield, of Leeds, in 1818; in Ireland, by Crampton, in 1823; in Scotland, by Syme, in 1828; and in the United States, by John C. Warren, in 1834.

The operation is usually required on account of caries, or caries and necrosis, of the heads of the contiguous bones, and should always be preferred to amputation of the arm, when it is possible to preserve a sufficiency of osseous matter to leave a good limb. Experience has proved that the danger of excision of the elbow-joint is, in general, very slight, when the operation is limited to the articular extremities of the bones; when the medullary canal of the humerus is exposed, there is always risk of myelitis, erysipelas, and pyemia, and the same is true, although in a less degree, of the medullary canal of the radius and ulna. Besides, the shorter the excised pieces are, the greater, other things being equal, will be the probability of a serviceable limb.

In regard to the mode of operating, surgeons have hitherto failed to agree upon

Fig. 789.



Excision of the Elbow-joint.

any particular standard, for the reason, doubtless, that no one method is applicable to all cases. Mr. Park, by whom the procedure was originally suggested, although never practised, thought the object might be attained by a single longitudinal inci-

sion along the posterior part of the elbow, as in fig. 789, from Erichsen, and the excision has often been effected in this way. Langenbeck, whose experience with this operation is very great, prefers this method to all others, and I am sure, from what I have seen of it, that nothing better could be desired, whether for complete or partial excision. Moreau employed an H-like cut, by means of which he obtained two large flaps, which, reflected in opposite directions, exposed the parts very freely. Some, again, as Jæger and Liston, avail themselves of a T-shaped incision with the horizontal limb on a line with the inner condyle, while others, among whom I formerly included myself, advocate a semilunar one, with the convexity downwards, on the ground that the wound affords more ready drainage.

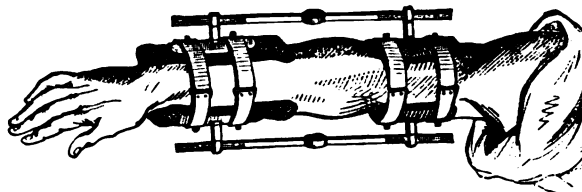
In performing the operation, the patient should incline somewhat towards his abdomen; and the incisions should be sufficiently ample to give the surgeon free room for the accomplishment of his design. An assistant is ready to compress the brachial artery, in the event of there being any likelihood of much hemorrhage, which, however, will rarely be the case, unless the articular vessels, which will necessarily be divided, have become much enlarged from protracted irritation. Care is also taken not to injure the ulnar nerve, as it courses along the inner margin of the olecranon. If the semilunar incision be adopted, the knife should be drawn across the back part of the limb, from the superior extremity of one condyle to that of the other, for a distance of about two inches and a half; the flap being then raised, the ligaments, if still remaining, are cautiously severed, and the tendon of the three-headed extensor muscle detached at its insertion. The instrument is next passed closely around the olecranon, and this process removed with the pliers. The joint being thus fairly exposed, the heads of the radius and ulna are liberated from their connections, and thrust through the wound by forcibly bending the joint and pushing the forearm upwards. The saw is now applied, and the diseased structure excised, with the precaution of avoiding, if possible, the attachment of the two-headed flexor and anterior brachial muscles, as their separation would seriously compromise the future usefulness of the extremity. The articular end of the humerus is removed in a similar manner. In cutting off the bones the ulnar nerve is drawn to one side with a blunt hook; but it is not necessary to protect the parts in front of them, as the brachial artery lies securely under cover of the anterior brachial muscle.

In the operation of Langenbeck, the incision is carried along the posterior surface of the joint, through the tendon of the triceps muscle towards the inner condyle, for a distance of at least four inches, of which two are above and two below the centre of the articulation. The soft parts are detached in the usual manner, the periosteum is carefully preserved, and the bones are severed with the saw and pliers.

Partial excision is conducted upon the same principles as complete. When only one bone is diseased or injured, the articular extremities of the other two must be cut away, experience having shown that, if this precaution be neglected, the operation is not only more dangerous to limb and life, but very liable to be followed by irremediable ankylosis.

During the after-treatment the limb is placed in an easy, flexed position, in a tin case, with an opening opposite the elbow to facilitate drainage, upon an angular splint, or, what is better than either, upon Heath's apparatus, delineated in fig. 790.

Fig. 790.



Heath's Splint in Excision of the Elbow.

By means of this contrivance, which is furnished with screws and a central hinge, the forearm can readily be maintained at any desired length and angle. The ends of the bones should be kept in tolerably close proximity with each other; for, as they are destined to unite by fibro-ligamentous tissue, it is important that this sub-

stance should be as short as possible. As the cure progresses, the forearm is gradually flexed, until, at length, it is brought to a right angle with the arm, passive motion being frequently practised to prevent permanent ankylosis.

When the after-treatment is judiciously conducted, there is not only usually no danger from the operation to the patient's life, but every reason to hope for a good result as it respects the use of the limb. Many of the persons subjected to this operation are afterwards able to pursue, with great satisfaction, their former occupation. Mr. Cock, of London, in 1857, had under his charge a man whose elbow had been excised, eighteen years previously, by the late Mr. Key, on account of scrofulous caries. He had enjoyed, throughout the whole interval, a very excellent use of the limb until a short time before his admission, when, in consequence of an attempt to work with it in a new position, disease again appeared, requiring a slight operation, which promised to be followed by further relief. The case affords a beautiful illustration of the triumphs of conservative surgery.

Excision of the elbow-joint on account of *gunshot* injuries has lately engaged much attention among military surgeons. Dr. S. W. Gross has collected 499 cases, of which 400 recovered, and 99, or 19.62 per cent. died. Of these operations he has ascertained that 79 were primary, with 9 deaths, and 114 secondary, with 23 deaths, the latter affording a ratio of mortality of 8.78 per cent. greater than that of early excision. Stromeyer and Esmarch have conclusively shown, contrary to the opinion generally received, that partial excisions are followed by better results as regards the mobility of the joint than total operations, a fact which sustains the views of the latter surgeon that the motion does not depend so much upon the extent of the parts excised, as upon the retention of a portion of the synovial membrane.

With regard to the condition of the limb after excision, the statistical results are most unsatisfactory, the wars of the Duchies, in which forty patients were subjected to the operation, alone affording any definite conclusions on this point. Of these, Esmarch says: "Six died, one is not yet healed; in one the forearm mortified, and it was necessary to remove it by amputation: the remaining thirty-two are completely healed, and have a more or less useful arm. As regards two of them, I have not been able to learn anything with reference to the power of motion they possess; of the rest eight have very extensive, nine more or less complete, power of motion. On the other hand, thirteen of the cases have more or less complete ankylosis of the joint."

Consecutive amputation is occasionally required, as in the case delineated in fig. 791, in which, on account of perforation of the elbow-joint by a conoidal ball, two inches of the lower extremity of the right humerus, along with the olecranon process, were excised, by Dr. Hewit. Two months subsequently the arm was removed near the shoulder.

Of 145 cases of excision of the elbow-joint for *disease*, tabulated by Heyfelder and Bæckel, 125 recovered and 20 died. In 7 cases, subsequent amputation was rendered necessary, and 94 of the successful cases regained useful arms. These facts correspond very closely with those deduced by Dr. Hodges from an examination of 119 cases, of which 104 recovered and 15 died, consecutive amputation being performed 15 times. Of the 89 recovering without amputation, 77 had more or less useful limbs. In 470 amputations of the humerus, 157 proved fatal, or in the ratio of about 33 per cent. It will thus be perceived that the results of these statistics are decidedly in favor of excision of the elbow.

Fig. 791.



Front view of an Excised Elbow.

EXCISION OF THE HUMERUS.

Excision of the shaft of the humerus is sometimes required on account of gunshot injuries, or fractures caused by severe falls, railway accidents, or machinery in rapid motion. In the first two Schleswig-Holstein campaigns, resection of the ends of the fragments was practised for the cure of gunshot lesions in 9 cases, of which 4 died, while of the remaining 5 several had very defective limbs. Subsequently resection was abandoned, the surgeons limiting themselves for the most part to the immediate removal of the splinters; and of 32 cases thus treated only 5 died, the others making excellent recoveries, with useful limbs, although in many the humerus had been terri-

bly shattered by cartridge shot. At Constantinople, as stated by Bandens, portions of the shaft of the humerus were excised 4 times, of which 2 died and 2 recovered. The table, collected by Dr. S. W. Gross, however, shows much more favorable results. Thus, of 207 cases, occurring in our Army and Navy, in the Schleswig-Holstein wars, and in the Italian hospitals, during the war of 1859, 152 recovered and 55 died, yielding thus a ratio of mortality of 26.57 per cent. These results are more encouraging than those of amputation of the arm for gunshot injuries, since of 3968 cases of the latter description, 2766 recovered and 1202 died, a percentage of mortality of 30.29. Expectant treatment, however, affords far more encouraging results in this class of injuries than either excision or amputation. Thus, of 1008 cases, inclusive of 693 that occurred in our late war, tabulated by Dr. Gross, 799 recovered and 209 died, the mortality ratio being 20.73 per cent., which is 9.56 per cent. less than that of amputation of the arm, and 5.84 per cent. less than that of excision in the continuity of the humerus. In 211 cases recorded by Demme, the time required for a cure varied from forty to sixty days, and in five instances a false joint formed. In none did consecutive necrosis take place, while of 240 amputations of the arm which came under his observation, necrosis of the stump occurred in 30.

Professor Langenbeck has, on several occasions, resected the entire humerus on account of gunshot injury, the patients making a good recovery, with a very excellent use of the limb. In one of these cases the head and upper half of the bone were removed soon after the accident, and five months subsequently the lower half along with nearly an inch of the radius and ulna. The new bone was about half the size of the original one, but the condyles were well formed, and the superior extremity strikingly resembled the natural head. In a pathological case, operated upon in 1864, Langenbeck removed at different intervals the entire humerus, ulna, and radius, with a sound cure and a very serviceable limb, the muscles having been left adherent to the periosteum, which was itself disturbed as little as possible.

The entire humerus, together with the heads of the radius and ulna, was removed, in 1864, by Dr. James B. Cutter, of New Jersey, on account of extensive necrosis, the effect of a gunshot fracture of the superior extremity of the bone, excised by another surgeon three days after the accident. The operation was performed eight months after the first, and consisted in extending the previous incision along the inner border of the arm as far as the elbow-joint. The bone was easily separated, and there was so little hemorrhage that no ligatures were required. The wound was completely healed by the end of the third week; and, with the aid of artificial means, the man was gradually regaining a tolerably good use of his limb.

EXCISION OF THE SHOULDER-JOINT.

Excision of this articulation is frequently rendered necessary on account of caries and necrosis of the head of the humerus, or of this bone and of the contiguous surface of the scapula. It has also been done, in numerous instances, on account of gunshot injury of the shoulder, attended with laceration of the soft parts and comminution of the upper extremity of the humerus. The head of the humerus was successfully excised, in 1869, by Professor Warren, of Baltimore, on account of an unreduced dislocation, the displaced bone pressing upon the axillary plexus of nerves, and thus causing great and constant suffering. Professor Blackman, in 1870, performed a similar operation, with equally happy results, on account of chronic rheumatic arthritis. The operation was first formally performed for caries of the head of the humerus in 1771, by Mr. James Bent, of Newcastle, England, although a nearly similar procedure had been executed as early as 1740, by Thomas, of Pezenas, in Languedoc. When proper care is exercised, as it respects the selection of the cases, and the mode of the procedure, I believe that it will seldom be followed by any bad effects, especially in pathological cases, while the patient will usually have a very good use of his limb. Less impairment of function, other things being equal, will necessarily ensue when a small than when a large portion of bone is removed. In an instance in which Lenton excised the entire humerus, except two inches of the lower extremity, the arm remained permanently stiff.

Various methods have been proposed and executed for the removal of the shoulder-joint. Thus, some content themselves with a vertical incision, extending from the acromion process down through the belly of the deltoid, nearly as far as the insertion of this muscle; some, again, prefer a V-shaped cut, the base looking upwards;

Moreau, who performed the operation a number of times, made a quadrilateral flap with the base below; Morel fancied that the easiest way of accomplishing the object was to make a semilunar flap over the most prominent part of the shoulder, not unlike that made in amputation; Mr. Syme employs two incisions, a perpendicular one through the middle of the deltoid, and an oblique one extending upwards and backwards from the inferior angle of the first. Professor Langenbeck makes a vertical incision from the anterior border of the acromion process, midway between the two tubercles of the humerus, in the direction of the long tendon of the biceps, from three to four inches in length, detaches the subscapular and spinatus muscles, opens the capsule of the joint, raises the periosteum, and saws off the bone at its neck or at the upper portion of its shaft, as may be found necessary. Dr. W. P. Moon, who has performed this operation four times—twice successfully—on account of gunshot injury, gives a decided preference to an incision carried along the posterior border of the deltoid muscle. The advantages claimed in this procedure are, greater facility of exposing and removing the head of the humerus, more ready drainage, greater rapidity of cure, and a rounder and fuller state of the shoulder after recovery. Finally, Professor Pancoast prefers a curvilinear cut, under the impression that it yields more room for the necessary manipulations. It cannot be denied that some of these methods afford the surgeon most ready access to the joint, and enable him to effect excision of the humerus with the greatest facility; but then they have the disadvantage, and a very serious one it is, of inflicting most severe injury upon the deltoid muscle, in consequence of the oblique and more extensive division of its fibres, and of thus greatly protracting the cure, as well as materially enhancing the danger. It is for these reasons that I have always limited myself, in the operations which I have performed upon the scapulo-humeral articulation, to the simple perpendicular incision, as depicted in fig. 792; and I believe this will generally be found to answer every purpose, while it is entirely free from the objections here adverted to. In one of my cases, treated in this manner, I was enabled to remove, without difficulty, upwards of four inches of the humerus, and the recovery was most satisfactory. The operation is generally the more easy because, in caries of the joint, there is nearly always very considerable atrophy of the deltoid muscle and absorption of the subcutaneous fat. The incision should begin just beneath the acromion process, and, descending nearly in a straight line, through the cushion of the shoulder, should terminate within a short distance of the inferior attachment of the deltoid. The knife is carried down, at the first stroke, to the bone, which is then thoroughly liberated from its connections with the soft parts by means of a stout, blunt-pointed bistoury, passed closely around its neck, so as to sever the tendons of the subscapular and spinatus muscles, the long head of the biceps being left undisturbed. The capsular ligament is generally destroyed by the disease, but, if any portion remain, it must be divided in the usual way. If more than the head of the bone requires removal, it will be necessary to separate any fleshy fibres that may be attached to the shaft. This step of the procedure may be greatly facilitated by the use of the instrument exhibited at p. 490, fig. 348. The bone is now pushed through the wound by depressing the elbow backwards, and the whole of the diseased portion sawn off, the soft structures being carefully protected from the teeth of the instrument. If the glenoid cavity is involved in the morbid action, the affected substance is scraped or cut away, the acromion process being dealt with, if need be, in a similar manner. Sometimes it is necessary to remove the head of the humerus and a large portion of the scapula, as in a case which occurred to Mr. Jones, of Jersey. The bleeding vessels being secured, the cavity is next washed out with cold water, the sinuses, if any exist, are properly pared, and the edges of the wound are approximated by suture and bandage, the arm

Fig. 792.



Appearance of the Wound after
Excision of the Head of the Humerus.

being secured to the side of the body, and the forearm supported in a sling. To favor discharge, a small tent should be inserted into the lower angle of the wound.

Fig. 793.



Fig. 794.



Flap Operations in Excision of the Head of the Humerus.

Fig. 795.



Caries of the Head of the Humerus.

The diseased appearances of the head of the humerus, in one of my cases, are well illustrated in fig. 795. The bone was sawn off upwards of an inch and a half below its tuberosity. The specimen affords conclusive evidence of the impossibility of a cure, under such circumstances, by ordinary methods.

Fig. 796.



Excision of nearly the upper half of the Humerus for Gunshot Injury.

The posterior circumflex artery is necessarily divided in this operation, and is frequently the only vessel that requires ligation. The axillary artery, vein, and plexus of nerves are entirely beyond the reach of the knife.

In the flap operation, the incisions may be made so as to represent the shape of a U, as in fig. 793, from Erichsen, or the outline of a V, as in fig. 794. In either case, the deltoid muscle is extensively divided, and easy access afforded to the articulation. The procedure, however, is one of great severity, and must sometimes be followed by grave consequences.

Dr. S. W. Gross has tabulated 749 cases of excision of this joint for gunshot injuries, of which 498 recovered, and 251, or 33.51 per cent., proved fatal. Of these operations 285 were primary, with 76 deaths, and 379 secondary, with 143 deaths, affording thus a result in favor of the former of 11 per cent. These facts are, practically, of the deepest interest, as showing the bad effects which may be expected from interference after the occurrence of severe inflammation with incipient suppuration.

During our late war, in addition to the head of the humerus, portions of the clavicle, or of the coracoid and acromion processes and neck of the scapula, were excised in 29 instances, with only 4 deaths, the result being as satisfactory as that of the ordinary operation. In many instances several inches of the shattered shaft of the humerus were removed along with the head of the bone, as in fig. 796, and several recoveries are reported with fair motion.

In this country, removal of the shoulder-joint was first practised for gunshot wound by Dr. William Ingalls, of Boston, in 1813, the patient, a soldier, making a good recovery with a

tolerably useful limb. In the American war with Great Britain, in 1812-14, three successful cases of excision of the shoulder-joint occurred on account of gunshot injury. In one of these, under the charge of Dr. Henry Hunt, of Washington City, the extremity of the humerus, a portion of the clavicle, and the acromion and coracoid processes were removed, but not until after the man had become greatly exhausted by copious suppuration and extensive sloughing.

Of 50 cases analyzed by Dr. Hodges, in which the shoulder-joint was excised for disease, 42 recovered, and 8 were fatal; 2 of the former, however, died at the end of a year of phthisis, and 2 others were not materially benefited. It would thus appear that 16 per cent. of all the cases were fatal, and 24 per cent. unsatisfactory. The patient usually obtains a very good use of his limb, ankylosis being an exceptional occurrence.

3. INFERIOR EXTREMITY.

EXCISION OF THE BONES OF THE FOOT.

The principal articulations of the lower extremity which require to be dealt with in this way are those of the hip, knee, and ankle; excision is occasionally practised upon some of the tarsal and tarso-metatarsal joints, and the procedure not unfrequently results in a good use of the foot. But I am quite sure that such an operation should never be performed upon the metatarso-phalangeal articulations and upon the joints of the toes, for the reason that the ankylosed and abbreviated member could not fail to be sadly in the way of the patient's convenience and comfort when he comes to wear his boot. The rules which apply to excision of the bones of the metacarpus and fingers are altogether irrelevant here, on account of the difference in the uses to which these parts are subjected. The hand is essentially a prehensile organ; hence, even if only one finger, although that should be the little one, or the metacarpal portion of the thumb, can be preserved, we shall render the possessor a most valuable service. The foot, on the contrary, is an organ of support, serving to receive and sustain the weight of the body during progression, and in the erect posture. The longer and broader, therefore, it is, the better able it will be to perform its important offices. But there is another view of the subject which must not be overlooked in a parallel of this kind; it is this, that, while the hand is perfectly free, the foot is constantly incased in a tight boot or shoe, a circumstance which renders it absolutely essential to the comfort of the patient that the whole limb, but more particularly the toes, should be as free from prominences and cicatrices as possible. It is for these reasons that the toes, when fatally injured or diseased, are never removed at their articulations or in their continuity, but always at their metatarsal junctions; when the operation is practised at these sites, as it occasionally is by young and thoughtless surgeons, the stump is always in the patient's way, and usually requires secondary amputation. Moreover, it is not only important that the foot should be free from painful and inconvenient scars and prominences, but that it should be firm and solid, otherwise it cannot possibly serve the purposes of a basis of support. We may excise a metacarpal bone, and yet, if proper care be taken during the after-treatment, the corresponding finger will retain, not only its symmetry, but also, in a considerable degree, its usefulness. But the result is very different when we remove a metatarsal bone without the toe with which it is articulated; as soon as the support afforded by that bone is gone, the member is unable to sustain itself, and, as a consequence, it constantly drops away from its fellows, to the great discomfort and annoyance of the individual. I believe, then, that excision of the bones and joints of the toes and metatarsus, ought, as a general rule, to be superseded by amputation, as altogether more likely to leave a serviceable and symmetrical limb.

Kramer excised the metatarso-phalangeal articulation of the great toe on account of caries as early as 1824, and a similar operation was performed three years subsequently by Roux. The tendency which occasionally arises during the after-treatment in the extensor tendons to pull the end of the toe upwards, may be promptly counteracted by their subcutaneous division, although in general this will not be necessary. Cases of this operation, followed by an excellent use of the great toe, have been reported by Pancoast, Regnoli, Fricke, Butcher, and others.

Examples of the successful excision of the anterior extremity of the first meta-

tarsal bone, in complicated dislocation, are mentioned by Textor, Josse, and others, the first of these surgeons having performed the operation as early as 1822. Blandin, Roux, and Jobert each removed the anterior half of this bone for caries and cystic degeneration; and the posterior extremity of the first phalanx of the great toe has been excised in two instances, with excellent results, by Champion.

The objections that have been urged here against excision of the toes and metatarsus cannot apply to exsection of the bones of the tarsus; the utility of the operation has, in fact, been tested in numerous instances, and, although it is impossible to lay down any specific rules for its performance, yet any surgeon of ordinary skill or anatomical knowledge may undertake it with a reasonable hope of success. The great difficulty of the procedure depends upon the close and intimate manner in which the different pieces of the tarsus are connected together, the thickness of the plantar tissues, and the course and depth of the plantar arteries. This, however, may generally be overcome by attacking the bone to be removed either from the margin of the foot, or from its dorsal surface, where the soft parts are comparatively sparse and unimportant. A useful guide to the diseased bone is commonly afforded by one or more sinuses, the situation of which is nearly always indicated by a red papule of granulations, and more or less discharge of sanious fluid.

Caries of the foot is the disease for which excision is most commonly required, and experience long ago demonstrated that the tarsal bones are those which are most liable to suffer in this way. Not unfrequently, however, the heads of the metatarsal bones participate in the lesion, and occasionally, again, they are its exclusive seat. It rarely happens, according to my observation, that only one bone, either of the tarsus or metatarsus, is affected; in general, at least two or three pieces are in a carious condition, and cases arise where every one suffers, the foot presenting a horribly swollen and deformed mass, full of sinuses, and the seat of excessive pain. Under such circumstances, of course, nothing short of amputation, promptly performed, affords any chance of relief.

When the caries is limited to the cuneiform bones, to these bones and the heads of some of the metatarsal bones, or, lastly, to the cuneiform bones and the adjoining portions of the cuboid and navicular bones, excision deserves a decided preference over amputation, and I am satisfied that the operation, if properly executed—that is, in a bold and uncompromising manner, the surgeon removing all the diseased structure—will generally be followed by highly satisfactory results. I have repeatedly extirpated nearly the whole of the cuneiform bones, together with the heads of several of the metatarsal, and also considerable portions of the cuboid and navicular, and yet the patient had a most excellent and useful foot, answering all the purposes of the natural limb. Access is easily obtained by a large horseshoe flap, with the convexity downwards, upon the dorsum of the foot, care being taken not to injure the sheaths and tendons of the extensor muscles. The removal of the affected bones, whether in part or in whole, must be effected by the cautious use of the gouge and mallet, aided by strong, narrow, probe-pointed knives, and long-bladed, slender pliers. Several mops must be at hand for sponging out the deep cavities made in the operation; and the bleeding, which, however, is seldom profuse, must be controlled, after the excision is completed, by compression, with or without styptics, according to the exigencies of the case.

The *calcaneum* has been excised in numerous instances, but for the most part only partially, on account of caries, necrosis, and fracture. Carnochan, Morrogh, C. R. Greenleaf, and Hunter McGuire have reported cases of successful excision of the entire bone, an operation first performed in 1814, by Monteggia. I have myself on three occasions removed the whole of the heel portion of the calcaneum for necrosis. When the entire bone requires excision, the best mode of procedure is that recommended by Mr. Erichsen, inasmuch as we are thereby enabled to preserve the integrity of the sole, a circumstance of great consequence to the patient after his recovery from the operation. In most of the methods heretofore practised the incisions are directed to be carried into the plantar region, so that the cicatrices are afterwards subjected to the pressure and friction of the shoe during progression, and thereby rendered liable to the occurrence of pain, induration, and ulceration. In the case reported by Dr. Carnochan the sole was not entered, but as the proceeding was somewhat more complicated than that suggested by the English surgeon, I feel inclined to accord the latter the preference.

"The patient," says Mr. Erichsen, "lying on his face, a horseshoe incision is

carried from a little in front of the calcaneo-cuboid articulation around the heel, along the sides of the foot, to a corresponding point on the opposite side. The elliptic flap thus formed is dissected up, the knife being carried close to the bone, and the whole under-surface of the os calcis thus exposed. A perpendicular incision, about two inches in length, is then made behind the heel, through the tendo Achillis in the mid line and into the horizontal one. The tendon is then detached from its insertion, and the two lateral flaps dissected up, the knife being kept close to the bones, from which the soft parts are well cleared, as in fig. 797. The blade is then carried over the upper and posterior part of the os calcis, the articulation opened, the interosseous ligaments divided, and then, by a few touches with the point, the bone is detached from its connections with the cuboid, which, together with the astragalus, must then be examined, and, if any disease is met with, the gouge should be applied. By this operation all injury to the sole is avoided, and, the open angle of the wound being the most dependent, a ready outlet is afforded for the discharges."

When the parts are thoroughly cicatrized, the patient may walk about with the aid of a shoe with a high heel stuffed with horse-hair, but great care must be taken for a long time not to bear too much weight upon it.

The cure, however, unfortunately, is not always permanent, owing to the outbreak of disease in the neighboring structures, and the consequent necessity of further interference. Of 10 cases collected by Mr. T. M. Greenhow, of New Castle, England, by whom the operation was first placed upon a sure and solid foundation, amputation of the foot was ultimately required in 2. Dr. Polaillon, of Paris, in 1869, published an elaborate memoir upon excision of this bone, based upon an analysis of 64 cases, in only 55 of which, however, the results are known. Of these, 39 recovered with useful limbs; 3 died; in 7, subsequent amputation was necessary, of which 2 were fatal; and in the remaining 6 the limb was more or less useless. Children and adolescents retained good limbs in at least eight cases out of nine; whereas in adults, the operation failed in half of the cases.

Of 42 cases of partial excision of this bone, analyzed by Mr. Henry Hancock, of London, the operation in 25 was performed for caries, in 13 for necrosis, and in 4 for injury. Of the 25 cases of caries, 14 recovered, of 7 the result is not given, 1 died, 1 submitted to amputation, and 2 underwent excision a second time. Of the 13 cases of necrosis, 4 got well, and of the 4 cases of injury 3, the result of 7 of the former being undetermined. Partial excision of the calcaneum was first performed two centuries ago by Formius for the removal of a musket-ball.

Excision of the *astragalus* was first performed by Fabricius Hildanus in 1670. Of 109 cases, analyzed, in 1866, by Mr. Hancock, 76 recovered with good and useful limbs; 2 underwent secondary amputation, with one recovery; 16 died, including the one in which secondary amputation had been performed; and in 14 the results are not known. The operation was required in 64 for compound dislocation; in 20 for simple dislocation; in 10 for caries; in 4 for compound fracture; in 1 for necrosis; and in 10 the causes are not stated.

Flattering as these statistics apparently are, they should be received with a great deal of reserve. In the first place, they are very limited, and, secondly, their results are altogether too favorable. Many fatal cases have, doubtless, occurred that have never been reported at all, and of the patients that survived the immediate effects of the operation not a few probably suffered afterwards either from a return of disease, as in the case of caries and necrosis, or, as in the case of accident, from destructive inflammation of the neighboring bones, with which the astragalus is so intimately united, and which must necessarily sustain more or less injury during the excision, however carefully executed. The operation, moreover, is one of extreme difficulty. Considering all these circumstances, it is questionable whether, in the great majority

Fig. 797.



Excision of the Calcaneum.

of cases, it would not be better to sacrifice the limb than to attempt to save it. At all events, it would certainly be well, in every instance of this kind, for the surgeon to place himself mentally in the situation of his patient, and to ask whether, if he were the subject of grave injury or disease of the astragalus, he would prefer excision to amputation. If he had all the facts on both sides of the question, on the one hand, the great danger of excision, the violent inflammation which would be sure to follow it, and the probability of a relapse of the disease; and, on the other, the comparative safety of amputation, the freedom from subsequent suffering, and the certainty of an excellent stump, one which might be readily adapted to an artificial limb, he would hardly hesitate as to the course he would pursue. He would unquestionably decide in favor of the removal of the leg above the ankle, or at the joint by Pirogoff's or Syme's method.

When excision of the entire astragalus is performed for caries, limited to its own substance, the best plan is to expose the ankle-joint at its anterior and outer aspect, by a semilunar flap, with the convexity downward, taking care not to injure any of the more important soft parts. The bone is separated, first, from its connections with the tibia and fibula, then from those with the calcaneum, and finally from those with the navicular bone. After its lateral attachments have been severed, the disarticulation will be materially facilitated by inclining the foot forcibly backwards, at the same time that an attempt is made with a stout pair of forceps to draw the astragalus out of its bed in the opposite direction. The cutting must be done with a thick, narrow, probe-pointed knife, kept close against the bone in order to avoid the plantar arteries, especially the internal, which would otherwise be in danger. The operation being completed, the calcaneum is brought up into the gap between the two malleolar prominences, where it is carefully maintained by appropriate apparatus, the foot resting at a right angle with the leg. Great attention is required during the after-treatment to prevent retraction of the heel by the action of the gastrocnemial muscles. Slight motion is occasionally procured between the contiguous surfaces, but, in general, there will be permanent ankylosis. The limb will necessarily be somewhat shortened.

I have in my possession a cast, kindly presented to me by Dr. James H. Hutchinson, of this city, which admirably exhibits the appearances of the foot and ankle after the removal of the entire astragalus. The patient was a boy, eleven years of age, on whom Dr. Peace performed the operation, at the Pennsylvania Hospital, in 1858, on account of a hurt received seven months previously. When the lad was discharged, the sore had closed, and he was in excellent health, as I ascertained by a personal examination. The foot, which had a tendency for a time to turn inwards, was nearly at a proper angle, but three-quarters of an inch shorter than the sound one. Some motion existed at the ankle-joint.

Partial removal of the astragalus may be effected with the gouge, and it will frequently be well, here as elsewhere, for the surgeon, when he begins the operation, to take some sinus in the neighborhood of the ankle-joint as his guide, a slight enlargement of the opening being often sufficient to enable him to obtain ready access to the seat of the disease.

In a case of caries of the astragalus and calcaneum, Mr. T. Wakley, of London, removed both these bones, together with the malleolar extremities of the tibia and fibula, recovery taking place with a strong and useful foot. Dr. J. C. Whitehill and Dr. T. G. Morton have each reported a case of successful excision of the entire astragalus and calcaneum on account of external injury.

Excision of the *cuboid* and *navicular* bones does not require any particular notice. When both these bones are involved in disease, the other pieces of the tarsus, and even those of the metatarsus, are also very apt to suffer, and then the question will arise whether Chopart's amputation should not supersede resection. When the cuboid alone is carious, it may easily be dug out with the gouge, but the operation will probably necessitate the removal of the fifth metatarsal bone with the little toe. Partial excision of the navicular bone may be effected in a similar manner.

In 1857, Dr. J. T. Bradford, of Kentucky, successfully excised the entire calcaneal and cuboid bones, together with a small portion of the astragalus, on account of caries, in a lad, fifteen years of age. An excellent recovery ensued, with a good use of the foot, the patient being able, by means of a padded shoe, to walk with great facility, and to work regularly on his farm.

Dr. H. J. Bigelow, of Boston, in 1855, removed the whole tarsus, excepting the calcaneum and astragalus, along with the heads of the second and third metatarsal bones. The operation was soon afterwards successfully imitated by Mr. Skey. In a case reported by Mr. Statham, the cuboid and external cuneiform bones were excised at a first operation, the scaphoid and remaining cuneiform at a second, and at a third the heads of the second and third metatarsal bones, with a small portion of the astragalus, the patient recovering with an excellent use of the foot, with very little alteration in its natural appearance.

EXCISION OF THE ANKLE-JOINT.

The ankle-joint not unfrequently suffers from scrofulous caries, as seen in fig. 798, from a patient at the College Clinic; it is also liable to necrosis, especially in com-

Fig. 798.



Caries of the Ankle-joint.

pound fractures and dislocations, followed by excessive inflammation. For the relief of these lesions the surgeon usually resorts to amputation of the lower part of the leg, and there can be no question that, as a general rule, it is by far the most expedient procedure, involving hardly any risk to life, and affording an excellent stump. In caries, however, of long standing, where the disease is limited to the articular surfaces of the joint, without any serious implication of the surrounding tissues, excision may be practised with a reasonable prospect of success, a strong and useful, although somewhat shortened, limb being left. The operation was first performed on account of disease, in 1792, by the elder Moreau, but, until lately, has not had a place in surgery, and even now professional sentiment is much divided in regard to it. It is done most conveniently by making two vertical incisions extending along the inner and outer margins of the leg, from the level of the ankle to a height of from two and a half to three inches; the lower angle of each cut is then connected by a semilunar one carried across the upper part of the instep, and the flap thus marked off being dissected up, the joint is exposed, the soft structures carefully detached from the two bones, and the articular ends turned out, and sawn off, if possible, on the same level, as in fig. 799. If the astragalus is diseased, the affected part is now removed with the gouge or pliers, when the raw osseous surfaces are placed in accurate apposition, and so maintained until consolidation has occurred, passive motion being duly attended to in order to obtain a short fibro-ligamentous rather than a bony union. In detaching the soft parts from the tibia and fibula, and severing their extremities, the utmost

Fig. 799.



Caries of the Inferior Extremities of the Tibia and Fibula.

care must be taken not to injure the tibial arteries or the tendons of any of the long muscles of the foot. The periosteum should also, if possible, be preserved, observation having shown that such a procedure greatly promotes the formation of new bone.

Dr. Spillman has tabulated 73 cases of excision of this joint for disease, of which 50 recovered, 14 died, and 6 underwent subsequent amputation, the result being undetermined in 3, affording thus a mortality of 20 per cent. Of the determined cases, in 20 the outer malleolus alone was removed, with 4 deaths, and one consecutive amputation, while both bones were excised in 50, with 10 deaths, and five subsequent amputations, the mortality being in each instance 20 per cent. Of 68 cases of this operation on account of compound fracture or dislocation, analyzed by Dr. Spillman, 15 failed; that is, 11 perished, and 4 submitted to subsequent amputation, with 2 deaths.

Of 19 cases, collected by Dr. S. W. Gross, in which the ankle-joint was excised for gunshot injury, 11 recovered, and 8 were fatal, thereby affording a mortality of 42.10 per cent. Of 16 cases of subperiosteal resection of this joint, performed by Professor Langenbeck, in the German-Danish war of 1864 and the Bohemian war of 1866, on account of extensive gunshot injury, for the most part of a very complicated character, 13 recovered, and 3 died. In some of the cases as many as three and four inches of the tibia and fibula were removed. All of the operations were secondary, and the periosteum, being much thickened, was completely preserved, along with the interosseous ligament, so far as it was present. The cure in most of the cases took place without any material shortening, an abundance of osseous material having formed in the direction of the excised bones. To these cases may be added an operation, performed by Langenbeck on a Prussian officer, wounded at the Alma, in which four inches of the tibia, with the greater part of the astragalus, were removed, with the result of recovery with ankylosis without shortening; and a successful case in the hands of Neudörfer, in Schleswig, in which, all the joint surfaces having been excised, the foot was preserved, with free motion and only one inch of shortening. It is thus seen that the mortality from subperiosteal excision of this articulation is only 16.66 per cent., a far better result than has been obtained from other methods.

EXCISION OF THE KNEE-JOINT.

It is not a little remarkable, when we consider the great size of the knee-joint, the importance of the structures which surround it, and the intimate sympathetic relations which exist between it and the rest of the system, that it should have been the first articulation which was subjected to excision for the relief of disease. The only plausible explanation which can be given of it is the fact that it is so frequent a seat of white swelling, or scrofulous ulceration, which, until after the middle of the last century, was never thought of being treated in any other manner than by the removal of the affected parts by amputation of the thigh. Excision of this joint was first performed by Mr. Filkin, of Northwich, in Cheshire, in 1762; as, however, no account of it appeared in print, no attention was attracted to it until the publication of the famous case of Mr. Park, of Liverpool, in 1781. Moreau, of France, executed it in 1792, upon a young man, laboring under white swelling. In 1809 the operation was performed by Mulder, of Groningen, in 1823 by Crampton, of Dublin, and in 1829 by Syme, of Edinburgh, the latter repeating it soon after in another case. From this period nothing of special interest occurred in regard to excision of the knee-joint until 1850, when it was revived by Sir William Fergusson. Since then the operation has been practised in numerous instances; and, although the results have been far from being uniformly successful, yet enough has been done to show that the procedure, if properly executed, holds out great promise of a strong and useful limb, in a class of cases which were formerly regarded either as entirely hopeless, or as remediable only by amputation. One of the most able and zealous champions of the operation, at present, is Mr. Butcher, of Dublin, who has perhaps done more than any one else to reduce it to rule.

It is not, of course, every case of diseased knee-joint that is proper for excision. The operation should, as a general rule, be refrained from when there is very extensive structural change of the bones, rendering it necessary to go much beyond their

articulating extremities; when the morbid action is of a strumous nature without well defined limits; and when the patient is so young that interference with the shafts of the femur and tibia would inevitably be followed by a serious arrest of development of the limb. In all such cases amputation should take the place of resection.

In regard to the manipulations, various plans have been suggested, any one of which will afford ready access to the diseased bones, but they are all objectionable, on the ground that, the most dependent part of the wound being closed, there is no outlet for the discharges. To remedy this difficulty it has been proposed to pierce the posterior wall of the wound, and to insert a gum-elastic tube to carry off the fluids as fast as they are secreted; a circumstance of paramount importance both as it respects the speedy restoration of the parts and the prevention of pyemia. There can hardly be any doubt that many, if not most, of the accidents that have followed this operation have been due, directly or indirectly, to the accumulation of pus in the bottom of the wound, and its consequent injurious action upon the bones, irritating and eroding their substance, and burrowing more or less extensively among the soft parts. Such, however, is the character of the tissues behind the articulation as to render it impracticable to approach the femur and tibia in that direction, or to leave the operator any choice in regard to the place of election.

Mr. Park readily accomplished his purpose by means of a crucial incision, the centre of which corresponded with the superior extremity of the patella, the perpendicular cut being nearly six inches in length, while the horizontal one reached almost half around the limb, which was in an extended position. Moreau, on the other hand, made an H-shaped incision, that is, a longitudinal incision along each side of the thigh and leg, between the vasti and flexor muscles, and a transverse one just below the patella. Professor Langenbeck carries a curvilinear incision along the inside of the joint, between the patella and inner condyle through the substance of the inner vastus; opens the joint at once, pushes the patella with its ligament outwards, and then divides the bones, saving the patella, if it be not diseased. I prefer myself, as does also that excellent operator, Dr. Humphry, of Cambridge, England, a large semilunar U-shaped or horseshoe flap, as seen in fig. 800, made by carrying the knife across the upper part of the leg, from one condyle to the other; this being carefully raised, affords a sufficient opening for dividing the ligaments, separating the soft parts, and turning out and sawing off

Fig. 800.



Excision of the Knee-joint.

Fig. 801.



Lower End of the Femur Excised.

Fig. 802.



Upper End of the Tibia Excised.

the ends of the bones. In general, not more than an inch of the femur, fig. 801, should be removed, and a still smaller slice should, if possible, be taken from the tibia, fig. 802; sometimes, however, it is necessary to cut off much more, the tibia,

for example, below its articulation with the fibula, and the femur above its condyle, and yet a useful limb be left. If any sinuses are found to extend into the substance of these bones, after they have been sawn off, they should be followed up with the gouge, and every particle of disease scooped out, with the same care and patience that the dentist drills out the cavity of a tooth preparatory to the introduction of the plug. Any burres that may have been exposed in the operation should also be removed, lest they occasion suppuration, and so retard the cure.

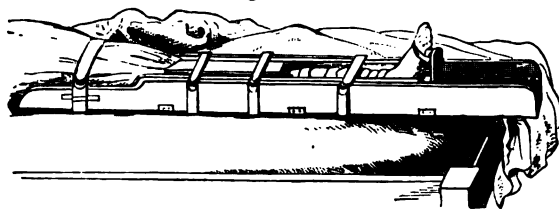
In most cases of disease of the knee-joint, requiring excision, the patella is implicated in the morbid process, and should, therefore, be removed along with the other bones; this course, however, necessarily involves the division of the tendon of the four-headed extensor muscle, and consequently the loss of any action which that muscle might exert upon the movements of the leg, in the event of the formation of an artificial joint during the progress of the case. Hence, the preservation of the tendon becomes a matter of great interest, as tending to augment the strength and usefulness of the limb. This can only be accomplished, however, when there is but little disease of the tibia and the patella; for, when the tubercle of the former bone is obliged to be excised, the tendon or ligament necessarily loses its attachment, and had, therefore, better be removed with the latter. All the ordinary procedures contemplate the ablation of the patella, and I am quite satisfied that it is, as a general rule, the most judicious practice, even when this bone is perfectly healthy. When the patella is retained, its articular surface should be divested of its cartilage, to promote its union with the surface of the femur, also previously rendered raw. If, notwithstanding this precaution, consolidation fails to occur, and the patella is found to interfere with the cure, lying loose under the integument, and thus keeping up irritation, no time should be lost in removing it altogether.

It might be supposed that, during the sawing of the bones, the popliteal artery would necessarily be endangered, but this is not the case, the vessel lying altogether beyond the line of the instrument. The hemorrhage, indeed, is usually very slight, ligation of the articular branches being all that is generally required.

During the after-treatment the limb should be retained in the extended position,

if much substance has been removed, but slightly flexed under opposite circumstances, in order to place it in the most favorable condition for usefulness in the event of ankylosis, which is so liable to happen after excision of the joints, notwithstanding all the precautions that may be taken to prevent it.

Fig. 803.

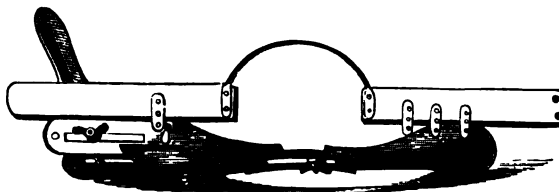


Butcher's Box for After-treatment in Excision of the Knee.

Among the more suitable contrivances for accomplishing this object is Mr. Butcher's box, fig. 803, the sides of which can be let down by hinges; it is well padded with horse-hair, and readily admits of the requisite degree of extension and counter-extension of the limb.

Mr. Price's apparatus, delineated in fig. 804, also answers admirably well. It consists of a McIntyre's splint, of thin tinned iron, with a foot-board, between

Fig. 804.



Price's Apparatus for After-treatment in Excision of the Knee.

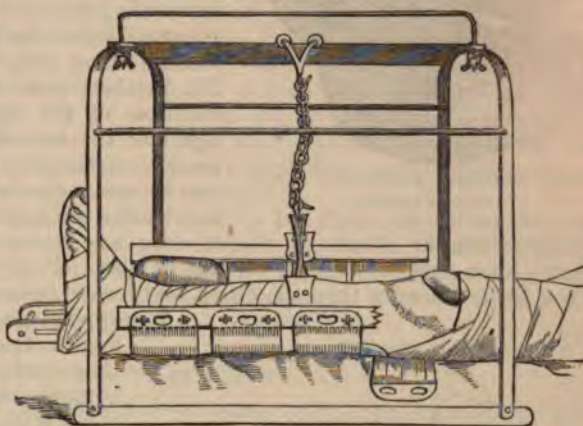
which and the leg there is an open space, in order that there may be no pressure upon the heel and the tendo Achillis. The portion of the apparatus corresponding to the popliteal space is slightly convex upwards, with a view of insuring more accurate apposition of the ends of the bones. A short splint, well padded, should be applied in front of the thigh,

while a long one, provided with a central iron hoop and a perineal strap, should be stretched along the outside of the limb. Dr. Packard has employed with good effect a

contrivance, sketched in fig. 502, in the chapter on fractures; and occasionally the limb may be swung, with great advantage and comfort, in Salter's apparatus, shown in fig. 805.

One of the most annoying occurrences to be guarded against is the tendency which the tibia has to be drawn outwards and backwards, by the action of the flexor muscles of the thigh. The best means of counteracting this disposition is the bandage, applied from the hip downwards, the leg being invested in the usual way; or, this failing, the subcutaneous section of the tendons of the offending muscles. When osseous union is expected, the bones should be sawn off a little slopingly behind, so as to enable the parts to afford the degree of flexion essential to the production of a serviceable limb. In this case the extremity should be placed over a double inclined plane, and be well supported with lateral splints, to prevent bowing of the leg.

Fig. 805.



An Excised Knee swung in Salter's Apparatus.

The statistics of this operation are of deep interest. In regard to the earlier cases, those of Filkin and Park completely recovered, the patient of the latter having obtained so sound a limb as to be able to go to sea and perform all the duties of a sailor. Moreau's patient died, several months after the operation, of dysentery; of Crampton's two cases, one recovered with a good limb, and the other perished at the end of three years and a half, exhausted by hectic irritation and repeated attacks of erysipelas. Of Mr. Syme's patients, one got well and the other died.

Pénières, in 1869, collected the statistics of 431 cases of resection of this joint, of which 300 recovered, 247 being cured without any other operation, 47 by secondary amputation, and 6 after reëxcision. Of these 247 cases the result was very good in 166, and bad in 27. The mean duration of the treatment was from six to eight months. The principal causes of death were shock, pyemia, erysipelas, and exhaustion.

Assuming that these data afford a fair average result, it will be perceived that the mortality from excision of the knee-joint is considerably greater than from amputation of the thigh in its inferior half. Nevertheless, no one can doubt that excision should always, in favorable cases, have the preference, on the principle that a natural limb, even when crooked, is preferable to an artificial one. Amputation possesses a decided advantage over excision when the patient is worn out by hectic irritation, and when the latter operation would be followed by so much shortening of the leg as to render it comparatively useless as an organ of progression.

The operation, as might have been supposed, has varied greatly, in regard to its results, in the hands of different surgeons. Thus, Professor Humphry, of Cambridge, England, had, up to 1868, 39 cases, in which he had excised this joint, mostly on account of chronic disease, of which 28 recovered, with sound, firm, useful limbs; 2 died, one, apparently, without any connection with the operation; and 9 underwent amputation, followed by 4 deaths. The late Mr. Jones, of Jersey, performed the operation fifteen times with only one death. Mr. Thomas Smith, of London, had, up to 1868, 14 cases, with a loss of 2. Of 17 cases of excision of the knee-joint, on account of caries, in France, from 1847 to 1868, 15 proved fatal, and 2 recovered with useful limbs. The principal operators were Sédillot, Gosselin, Dolbeau, and Giralès.

Dr. S. W. Gross has tabulated 35 cases of excision of the knee-joint for gunshot injury, of which 11 recovered, and 24, or 68.57 per cent., died. The mortality of total excisions, a specimen of which is illustrated in fig. 806, is greater than that of par-

Fig. 806.



Excised Knee-Joint. A round Ball rests in the Inner Condyle.

shorter than the other. A similar case has been reported by Dr. Keith, in a boy whose knee was excised at the age of nine. Five years afterwards the limb was seven inches shorter than the other, and looked, when compared with it, like a mere

Fig. 807.



Shortening after Excision of the Knee.

tial excisions by 33 per cent., while primary operations are less dangerous by 10 per cent. than secondary resections.

In operating upon young persons, Professor Humphry suggests the propriety of making the section through the epiphysis, and not through the shaft of the bones, lest, their growth being thus arrested, great deformity from shortening should occur. These effects are strikingly illustrated in the adjoining cut, fig. 807, taken from a case of Mr. Pemberton, of Birmingham. The patient, at the time of the operation, was twelve years of age, and the amount of bone removed was rather more than three inches and a half, of which about two inches and a half belonged to the femur. Six

years after the operation the limb was nine inches shorter than the other. It would thus appear that a useful limb cannot be obtained when this operation is performed through the shaft of the bone before the completion of the ossific process, the epiphysis being indispensable to its full development. The annexed cut, fig. 808, affords a good idea of the result of the operation in the adult. The drawing was taken two years after the operation, which was performed by Mr. Hancock.

Fig. 808.



Excision of the Knee Two Years after the Operation.

EXCISION OF THE PATELLA.

The patella, although not often diseased, is occasionally affected without the femur and tibia participating in the morbid action. In a man under my care, some years ago, the bone was completely exposed, and almost entirely necrosed, from frost-bite, its surface being as black as charcoal, and its substance greatly softened. By means of the gouge I cut away nearly the whole thickness of the bone, leaving merely its inner table, pared the edges of the ulcer in the soft parts, and, using warm water-dressing, succeeded in effecting an excellent cure, the joint gradually recovering from the stiffness into which it had been thrown by its protracted disuse.

A case in which the entire patella was removed on account of necrosis, the result of a fall, was reported in the *North American Medico-Chirurgical Review* for 1860, by Dr. O. B. Knobe, of Missouri. Although the cavity of the articulation was exposed during the operation, the patient, a man, twenty-one years of age, made an excellent recovery, followed by a good use of the limb.

Of 11 cases of excision of the patella, analyzed by Dr. Oskar Heyfelder, 9 recovered, and 2 died, one from gangrene, the other from suppuration. In 8 cases the resection was complete, in 3 partial. The causes necessitating the operation were, in 5 cases, caries, in 3 fracture, and in 3 gunshot injury. In 3 of the cases which survived the excision subsequent amputation was required.

EXCISION OF THE BONES OF THE LEG.

Excision of the long bones of the lower extremity can be practised only to a certain extent, as the removal of any considerable portion would deprive the limb of its solidity, and so render it useless as an instrument of progression and support. Several inches of the shaft of the femur might be excised, and yet, if osseous union occurred, the thigh would answer an excellent purpose. In badly-treated fractures the limb is often shortened to this extent, the patient walking well afterwards with the aid of a high-heeled shoe. A loss of several inches of the body of the tibia would be a serious accident unless it were accompanied by a corresponding loss of the fibula, in which case, solid union taking place, a good leg might result, while, if the fibula retained its integrity, the limb would not be sufficiently firm for locomotion.

To the above statements the fibula forms a striking exception. The loss of a portion of this bone, or even the whole of it, except its malleolar extremity, does not, as is well known, materially affect the functions of the leg and foot. Excision of the entire fibula, originally proposed by Desault, was first executed by Percy and Laurent; Seutin has also performed the operation, and other surgeons, as Bécclard and Elliot, have removed considerable pieces of it; generally on account of caries, caries and necrosis, or hypertrophy from syphilitic disease. A case of excision of the entire fibula for fibro-cartilaginous degeneration of that bone was reported, in 1858, by Dr. A. R. Jackson, of Chicago. The patient, a female, thirty-seven years of age, made a good recovery with a useful limb.

In performing the operation, the bone, exposed by a longitudinal incision, is carefully isolated at its superior extremity, and either disarticulated from the tibia or divided with the pliers. Taking now hold of this part, and using it as a handle, the operator cautiously detaches the remainder of the bone from its muscular connections, and, lastly, from the tibia and astragalus below, keeping all the while the point of his knife as closely against the osseous surfaces as possible. The excision is usually attended with a good deal of hemorrhage, and, unless proper circumspection be exercised, the peroneal artery may be wounded. During the after-treatment care must be taken to prevent inversion of the foot, to which there is generally a decided tendency whenever the external malleolus is removed.

Excision of the shaft of the tibia is a less dangerous operation than amputation of the leg, as is shown by the subjoined table, compiled by Dr. Heyfelder:—

Causes.	Number.	Survived.	Successful.	Partial.	Died.
Fractures	65	47	43	4	18
False-joints . . .	11	11	10	1	0
Deformities . . .	16	15	14	1	1
Curvatures . . .	11	11	11	0	0
Original disease . .	22	20	19	1	2
Total	125	104	97	7	21

Of excision of the bones of the leg on account of fracture three-fourths are completely, and one-fourth partially, successful, five-sixths surviving the effects of the operation. Of amputations of the leg, on the contrary, for all causes, one-third die; after primary operations one-half.

Of 172 cases of excision of the bones of the leg on account of *gunshot* injuries, tabulated by Dr. S. W. Gross, 137 recovered, and 35 died, or in the ratio of 20.34 per cent., which is less than that of amputation of the leg for gunshot injuries by 13.71 per cent. In 19 of the above cases, portions of both bones were excised, with 4 deaths; the tibia was the seat of the operation 72 times, with 15 deaths; and the fibula was excised in 81 instances, with 16 deaths.

EXCISION OF THE HIP-JOINT.

Excision of the head of the femur was originally performed in 1822, by Mr. Anthony White, of London, and, although it was soon afterwards repeated by Hewson, of Ireland, Oppenheim and Textor, of Germany, Seutin, of Belgium, and Brodie, of England, it was not until after its adoption by Sir William Fergusson that it met with general favor in Great Britain. In France it was performed for the first time by Roux in 1847, and in this country in 1852, by Professor Henry J. Bigelow, of Boston. The whole of the hip-joint was originally removed by Mr. Hancock in 1856. The operation is now seldom practised for injury, as it is nearly always fatal; and the great objection that has been urged against it in coxalgia, is that the morbid action often extends to the acetabulum, if not also to the pelvic cavity; some, indeed, have even gone so far as to assert that this is always the case in the more confirmed stages of the disease, which, however, is not true, as my dissections fully satisfy me. But, granting, for the sake of argument, that it is, the fact would not, in my opinion, constitute a valid objection against the procedure, seeing how easy it would be, in most instances, to gouge out all the carious structure, and thus leave the parts in a condition for gradual repair. When the acetabulum is deeply involved, a circumstance, however, which cannot always be determined beforehand, either from the symptoms or an examination with the probe, the case will, of course, be proportionately more unfavorable, but even then we need not despair of an ultimate cure, provided the operation is conducted with the requisite

care and skill. Left to itself the disease, in this condition, nearly always proves fatal, life being gradually worn out by hectic irritation and profuse discharge. Assuredly, then, unless the patient is utterly prostrated, both science and humanity would dictate the propriety of interference in the hope of rescuing him from his impending fate. I am satisfied that conservative surgery has not yet had fair play in this class of cases of hip-joint disease; the objection, I conceive, ought not to lie against the operation, but against the time at which it is performed, which is often too late to afford the benefits which it would otherwise be capable of conferring. When the head and neck of the thigh-bone alone are diseased, excision, early and judiciously practised, will not only prevent much suffering, but be instrumental in saving many lives. When the disease has committed such ravages as are displayed in fig. 809, from a drawing of one of my clinical cases, it is impossible for any surgeon to produce a good result.

In contemplating the manual part of the operation, several plans suggest themselves to the consideration of the surgeon. In the first place, he may adopt the method followed by White, of making simply one longitudinal incision, in the axis of the head and neck of the bone, of which he was thus readily enabled to remove four inches; or he may give his incision a T, L, or V-shaped appearance; or, finally, what is preferable to any of these procedures, he may form a semilunar flap of the gluteal muscles, with the convexity downwards. This plan of incision has the advantage not only of allowing free access to the joint, but also of

Fig. 809.



Ravages of Hip-joint Disease.

affording a ready outlet for the discharges at the lower and outer angle of the wound. The superior extremity of the femur, being thus exposed, is thrust through the opening, as seen in fig. 810, from Erichsen, by carrying the limb across the sound one, rotating it inwards, and then pushing it up, when it is to be divided immediately below the limits of the morbid action, fig. 811, by means of a narrow saw, the soft parts being carefully protected from injury during the movements of the instrument. The great trochanter, however sound, should always be included in the operation, otherwise it will be sure to interfere more or less seriously with the healing process by projecting into the wound, and obstructing discharge. Any disease that may exist in the acetabulum, whether at its margin or in its bottom, is to be freely removed with the gouge, chisel, knife, or scraper. There is seldom much bleeding, but a few small arteries may require ligation. The wound is approximated in the usual way, a small tent being inserted at the external and inferior angle; and the limb, placed in the straight position, is supported with a carved splint, with a window opposite the joint, to admit of the necessary examination and dressing. Until the primary effects of the operation are over, all attempts at extension and counter-extension will be likely to

Fig. 810.



Excision of the Hip-joint.

Fig. 811.



Portion of Femur removed for Hip-joint Disease.

prove extremely painful, if not positively mischievous; but by degrees this must be rigidly attended to, lest the limb, when well, be too short to be either seemly or useful. The object may, generally, be readily attained either with a bracketed Desault splint, or with the apparatus of Fergusson, depicted in fig. 812, the exten-

Fig. 812.



Fergusson's Apparatus for the After-treatment in Excision of the Hip-joint.

sion in the latter case being made from the opposite thigh by means of a laced socket having a band attached to the upper extremity. One of the difficulties expe-

rienced after the operation is to keep the end of the femur in contact with the acetabulum.

The length of femur requiring to be excised must, of course, be very variable. Sometimes mere removal of the head with a portion of the neck will suffice, but most commonly it will be necessary to include more or less of the shaft. In a case operated upon by Dr. William H. White, of Delaware, he excised the head of the bone along with about four inches of the shaft, and succeeded in effecting an excellent cure, notwithstanding that the patient, a man, nearly thirty years of age, had been greatly exhausted by long-continued suffering from coxalgia.

Dr. Ashhurst, in 1870, analyzed 376 cases of this operation, in only 327 of which, however, the results are known. Of these 164 recovered, and 163 died, thus affording a mortality of 49.85 per cent; 123 were examples of complete excision, of which 58, or 47.15 per cent., died; 47 were instances of partial excision, with 22 deaths, or a mortality of 46.81 per cent.; and of 157 cases, in which the form of operation is not stated, 83, or 52.87 per cent., perished. Of the 164 recoveries, 110 were reported as having useful limbs. In 35 cases, collected by Dr. Good, in which the shortening of the limb is noticed, the least amount was six lines, and the greatest four inches. The tables of Dr. Ashhurst show that partial excision of the hip-joint is fully as dangerous as when the operation involves both the thigh-bone and acetabulum. The most favorable age for the operation is from the fifth to the tenth year, the mortality being then only 25 per cent.; before the fifth year it is 36 per cent., and after the tenth year it rises rapidly until it reaches 75 per cent. for all periods of life after the thirteenth year.

It will thus be perceived that the mortality from this operation is immense, a circumstance which is not surprising when it is remembered that it is often performed, as a dernier resort, when all other means of relief have failed, and when life is rapidly ebbing away under the wasting effects of the disease. Doubtless, too, the results of the operation are much more favorable in the hands of some surgeons than in those of others. As a proof of this, it may be stated that, of 12 cases in the practice of Mr. Erichsen, only 2 proved directly fatal; 5 completely recovered, 3 were lost sight of after they had left the hospital, and 2 died from constitutional disease, one eleven months and the other two years after the operation. Mr. T. Holmes, on the other hand, up to 1868, had 7 deaths out of 19 cases, in 6 of which the fatal issue was due to the direct effects of the operation, 5 of them dying of pyemia, and 1 of gangrene of the wound.

The time and causes of death are various. In some death occurs within the first week, ten days, or a fortnight after the excision, either from inflammation, excessive suppuration, secondary hemorrhage, erysipelas, pyemia, or phlebitis. In others the patient recovers from the immediate effects of the operation, but falls a victim, at a variable period, to intrapelvic abscesses, caries or necrosis, phthisis, Bright's disease, enlargement of the liver, tubercular meningitis, or some other intercurrent malady. In many cases the operation is performed imperfectly, or after the disease has made such progress as to render recovery absolutely impossible. Serious involvement of the acetabulum materially enhances the danger of the operation. Dr. Hodges, in 1861, found a mortality of 51.72 per cent. when the acetabulum was gouged, scraped, or cauterized, and only 44 per cent. in cases of non-interference.

Amputation at the hip-joint is rendered necessary when excision is inapplicable, and life is threatened by hectic irritation, profuse discharge, or other causes. Great care should be taken in its performance to guard against hemorrhage, the smallest quantity of which might occasion irreparable mischief. Under the most favorable circumstances, the operation is an experiment which must often be followed by fatal results. Of eight cases tabulated by Dr. Ashhurst, four recovered.

The appearances of the limb after excision of the hip-joint for coxalgia are well illustrated in fig. 813, from a case of Mr. French, of London. The drawing was taken twelve years after the operation.

Dr. G. A. Otis, of the Army, has collected 85 cases of excision of this joint on account of gunshot injury, fig. 814, of which only 8 recovered, the ratio of mortality being 90.6 per cent: 39 operations were primary with 3 recoveries; 33 were intermediary with 3 recoveries; and 13 were secondary with 2 recoveries. Of these cases 63 occurred in our late war.

Fig. 813.



Appearance of the Limb Twelve Years after Excision
of the Hip-joint.

roughly inverted during the operation. When more room is required than usual, the surgeon may make a T-shaped incision, with the base downwards, to afford a better outlet for the discharges. Great care is taken not to open the capsular ligament of the hip-joint.

Fig. 814.



Excised Head and Neck of Left Femur.

Dr. Hodges has constructed from a variety of sources a table of 21 cases of removal of the head of the femur, spontaneously separated from the rest of the bone, of which 5 proved fatal.

EXCISION OF THE GREAT TROCHANTER.

Excision of the great trochanter is occasionally required on account of caries of its substance. It was first performed by Tenon, in 1798, and has since been repeated in a considerable number of instances, for the most part with a very gratifying result. The principal operators have been Velpeau, Textor, J. F. Heyfelder, Teale, Willard Parker, and Fergusson. The latter has had two cases, one of which proved fatal at the end of the first week, from an attack of erysipelas.

The operation itself is not difficult of performance, the carious prominence being easily exposed by a longitudinal or slightly curvilinear incision, and removed with a small saw, the gouge, or the pliers; the hemorrhage is usually inconsiderable. The two circumflex arteries are endangered only when the knife is obliged to be carried deeply and extensively around the base of the trochanter. The excision of the bone will be much facilitated if the limb is tho-

CHAPTER XXII.

SPECIAL AMPUTATIONS.

1. SUPERIOR EXTREMITY.

AMPUTATION OF THE HAND.

THE fingers may require removal either in their continuity or at their articulations. When the distal phalanx alone is involved, as when it is in a carious or necrosed condition, the operation should, if possible, be limited to the bone, the nail and soft parts being preserved. In disease of the bone from whitlow, such a procedure is nearly always feasible, and, when the periosteum has not been destroyed, it is not unfrequently followed by a reproduction of the phalanx, although rarely in a perfect manner. It is only, therefore, when the parts have been crushed by machinery or some other cause, that, as a general rule, the finger should be cut off at the last joint. The operation is performed by making a short, semi-lunar incision from one side of the finger to the other, on its dorsal surface, its convexity presenting towards the nail, as seen in fig. 815. Turning back the integument, the knife is inserted into the articulation, and, the ligaments being divided, is drawn forwards, in close contact with the

Fig. 815.



Amputation of the Finger at the Distal Articulation.

palmar aspect of the bone, so as to form a large convex flap, which is then retained by several points of suture.

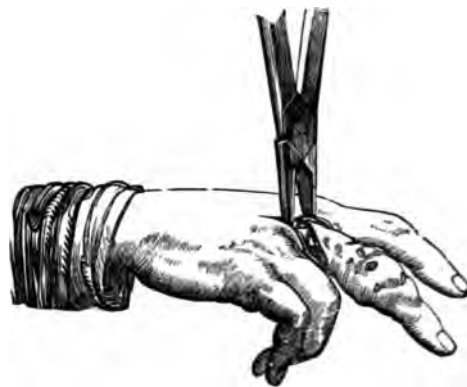
Amputation of the finger in the continuity of the second phalanx may be performed either by the circular method, or by two flaps taken laterally or from the

Fig. 816.



Amputation of the Finger at the Metacarpo-Phalangeal Joint.

Fig. 817.



Removal of the Bone with the Pliers.

dorsal and palmar surfaces, the bone being divided with a pair of sharp pliers. It is hardly necessary to add that it is always desirable to save as much of the member as possible, both on account of utility and seemliness.

Excepting the index finger, amputation should never be performed at the first phalangeal articulation, as the stump thus left would not only be disfiguring, but inconvenient. Hence, when the operation is required, it is much better to remove the bone at its junction with the metacarpal bone. This may readily be done by making two lateral flaps by circumscribing the posterior extremity of the first phalanx by two long, semilunar incisions, fig. 816, commencing at the centre of the knuckle of the metacarpal bone behind, and terminating at the middle of the palmar aspect of the member on a level with the web of the contiguous fingers. During the disarticulation, the finger is forcibly flexed, so as to afford an opportunity of severing the extensor tendon above the joint, as it would otherwise be in the way of the stump. Before approximating the flaps, the projecting portion of the knuckle of the metacarpal bone should be cut off with the pliers, as in fig. 817, in order to give the parts a more seemly appearance. Generally, two small arteries require the ligature. During the cure, the fingers must be confined upon a carved splint, otherwise they may overlap each other, and thus become, in a great measure, useless.

In amputating the index finger, a very useful stump may be formed by disarticulating the middle joint, especially in laboring subjects, or in those engaged in mechanical pursuits. Under such circumstances, indeed, a stump hardly an inch long occasionally answers an excellent purpose. In the rich, on the contrary, the hand will present a better appearance if the finger be removed at its connection with the metacarpal bone.

The stump left in the removal of the index-finger will be greatly improved if the radial margin of the metacarpal bone be cut off obliquely from behind forwards so as to diminish the size of the knuckle. A similar plan may be adopted in amputation of the little finger. In the annexed cut, fig. 818, the two bones are left intact.

It is seldom that all the fingers are simultaneously affected by disease, so as to require removal at the metacarpophalangeal joints, but such a procedure may become necessary on account of accidents crushing the bones and extensively bruising and lacerating the soft parts. The operation, which is sufficiently easy, is performed by making two flaps, one on the dorsal and the other on the palmar aspect of the hand, by two incisions, slightly convex in front, the posterior extending over the roots of the fingers, about three-quarters of an inch in front of their junction with the metacarpal bones, while the anterior one is carried across the hand on a line with the web of the fingers. The best plan is to form the dorsal flap first, and then, after having reflected it back, and divided the tendons and ligaments, to fashion the other by cutting from above downwards, and from behind forwards. The appearance of the stump will be greatly improved if the projecting portion of each knuckle of the metatarsal bones be sloped off a little with the pliers.

A useful, and not unseemly, stump may be formed by amputating the metacarpal bones in their continuity, leaving, perhaps, the thumb or one of the fingers, the principal flap being taken from the substance in the palm of the hand. In case of accident, crushing the bones of these pieces, the operation might be performed through their posterior extremities, from a third of an inch to three-quarters of an inch in front of their junction with the second row of carpal bones, or even at the carpo-metacarpal articulations, although, from the irregularity of the contiguous surfaces, the task would by no means be an easy one, nor would the resulting stump be as smooth as it ought to be, either for usefulness or seemliness.

Cases occur, both from accident and disease, demanding the removal of one of the metacarpal bones along with the corresponding finger. The operation is executed by making a triangular incision over the back of the hand, the apex of which is directed towards the wrist, while the base extends around the root of the finger in front, hardly any integument being sacrificed. The extensor tendon being cut far back, the bone, isolated from its muscular connections, is either separated at its

Fig. 818.

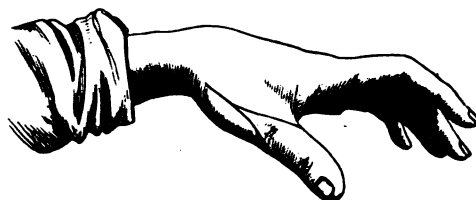


Amputation of the Index and Little Fingers.

carpo-metacarpal articulation, or divided in its continuity, in a sloping manner, by means of the pliers.

Amputation of the *thumb* at the distal joint, or in the continuity of its first phalanx, may be performed in the same manner as amputation of the fingers, and, therefore, does not require any particular notice. When both its bones are fatally implicated, whether by disease or accident, the hand will exhibit a much more seemly

Fig. 819.



Amputation of the Thumb and Metacarpal Bone.

Fig. 820.



Appearance of the Hand after Amputation of the Thumb.

appearance if the member be removed at the carpo-metacarpal joint. For this purpose, a triangular incision is made along the radial aspect of the hand, beginning about an inch in front of the styloid process of the radius, one line extending towards the centre of the web between the thumb and index finger, while the other passes around the outside of the head of the metacarpal bone, a little behind the joint, both meeting in front of the palm, as represented in fig. 819. The muscles being now detached, and the extensor tendons severed behind, the disarticulation is readily effected by bending the thumb forcibly inwards towards the ulnar margin of the hand. In performing the operation, the hand is placed in a state midway between pronation and supination, the fingers being fully extended and the thumb abducted. Care must be taken to include a full supply of integument in the incisions. When the flaps are properly shaped, they usually unite by the first intention, and leave a very insignificant cicatrice. The annexed cut, fig. 820, shows the appearance of the hand after the parts are healed.

Fig. 821.



The *little finger* is sometimes removed along with the metacarpal bone, at its junction with the unciform bone. Two incisions are made over the back of the hand, extending from the carpo-metacarpal articulation forwards, along each side of the root of the finger, and terminating at the centre of its palmar aspect, on a line with the web which connects it with the ring finger. The soft parts are now carefully detached from the bone, which is then forcibly flexed and disarticulated by inserting the knife into the back of the joint. Unless this rule be closely followed, the operation will prove difficult, on account of the peculiar conformation of the articulating surfaces of the two bones.

A useful stump may sometimes be made, in disease or accident of the hand and fingers, by preserving the carpus, or the carpus and a portion of the metacarpus. The adjoining sketch, fig. 821, kindly sent to me by Dr. Lente, represents a case of this description. Notwithstanding the loss of a large portion of the integument, the parts cicatrized very firmly, and the patient derived great comfort from the use of an artificial hand, the motions of the wrist-joint remaining unimpaired.

AMPUTATION AT THE WRIST.

Disarticulation at the wrist should always be preferred to amputation of the forearm whenever it is practicable, inasmuch as the mutilated extremity affords a much longer lever, which may afterwards be used with great advantage for various purposes, at the same time that it is more easily adapted to an artificial hand. I have

repeatedly seen persons who, after this operation, enjoyed an amount of action in the limb that was truly astonishing, and who expressed very great satisfaction at having so good a weapon of defence in accidental pugilistic encounters, the long stump enabling them to deal a most powerful blow. The operation is performed by making two flaps, an anterior and posterior, about two inches long, the convexity looking forwards towards the hand, as shown in fig. 822. They should be formed by cutting from without inwards, as we are thus enabled to give them a much better shape. The incision should extend from the styloid process of the ulna to that of the radius, which should previously be felt for, and then taken as guides to the knife. The disarticulation is effected by inserting the instrument into the posterior

Fig. 822.



Amputation at the Wrist.

Fig. 823.



Wrist, Carpal, and Metacarpal-joints.

part of the joint, the hand being forcibly flexed, and held perfectly prone at the time. This step of the operation will be greatly facilitated if the surgeon bear in mind the peculiar conformation and arrangement of the two surfaces of the joint, as seen in fig. 823. The hand being removed, the styloid processes are cut off on a level with the cartilaginous incrustation of the ulna and radius, when, the arteries of the wrist being tied, and the extensor and flexor tendons, if necessary, properly retrenched, the flaps are approximated and retained in the usual manner.

Of 146 cases of amputation at the wrist on account of gunshot injuries, tabulated by Dr. S. W. Gross, 100 recovered, and 46, or 31.5 per cent., died; the ratio of mortality being greater by 4 per cent. than that of removal of the forearm. Thirty-nine of these operations were performed in the Army and Navy during our late war, with only 2 deaths, or a percentage of mortality of 5. The French surgeons in the Crimea lost nearly one-half of their cases.

AMPUTATION OF THE FOREARM.

The forearm may be removed in its continuity in any portion of its extent, but when the surgeon has his choice, the operation should be performed as low down as possible, for the reason that, as stated in the preceding paragraph, the longer the stump is the more useful it will be. The flap method is the one which I usually prefer, but the circular also answers exceedingly well, and is regarded by many as altogether superior to it. When the patient is very fleshy, it is best to form both flaps by transfixion, one on the anterior and the other on the posterior surface of the limb, as in fig. 824; under opposite circumstances, one should be fashioned by cutting from without inwards, and the other by cutting from within outwards, as we are thus enabled to give them a more suitable shape and size. The extremity is held in a state midway between pronation and supination, the brachial artery is compressed by a tourniquet or the fingers of an assistant, the interosseous structures are divided on a level with the retracted flaps, and the saw is worked in such a manner as to sever both bones simultaneously, or, if practicable, the ulna a little

before the radius, as the latter, from its more direct connection with the hand, affords a better support during the operation, and thereby prevents splintering of the osseous tissue. This occurrence, however, may generally be effectually obviated if the surgeon, during the sawing of the two bones, takes care to apply his thumb and fingers strongly to the interosseous space.

Fig. 824.



Flap Amputation of the Forearm.

In performing the circular operation, it is advisable, on account of the smaller quantity of tissue, to draw the soft parts forcibly back by means of a three-tailed retractor, but such a procedure is never necessary when the amputation is done as here described. The radial, ulnar, and interosseous arteries alone generally require ligation.

Fig. 825.



Short Stump of the Forearm.

I have seen cases of amputation of the forearm about two inches or two inches and a half below the elbow, with a most excellent result, the stump being rounded off and well shaped, perfectly movable, and quite serviceable. The annexed drawing, fig. 825, taken several years after such an operation, exhibits the appearance of the limb.

Teale's amputation is seldom employed in the removal of the forearm. It is not only more troublesome than the ordinary methods, but is mainly applicable to cases of gunshot and other injuries attended with great loss of substance. It is executed upon the same principle as amputation of the leg.

Dr. S. W. Gross has tabulated 1327 cases of this operation on account of gunshot injuries, of which 962 recovered, and 365 died, thus affording a percentage of mortality of 27.50. Nearly one-half of these cases occurred in the Army, with a mortality of only 16.52 per cent.

AMPUTATION AT THE ELBOW-JOINT.

Amputation at this joint was, until a comparatively recent period, seldom performed; a circumstance the more surprising when it is considered what an admirable stump it leaves, what little risk it involves, and how promptly the parts usually heal. Besides these advantages, which experience has fully established, the operation is one of the most easy in surgery, and may, therefore, be performed by any one who has a competent knowledge of the anatomy of the articulation. Two flaps are formed, the principal one in front of the elbow, at the expense of the muscles in that situation, and the other, which is entirely cutaneous, behind, the length of the former varying from two and a half to three inches, according to the diameter of the limb. The forearm being slightly flexed, so as to bring the sharp edge of the coracoid process on a line with the articular surface of the humerus, the surgeon transfixes the structures in front of the joint, on a level with the two condyles, and, carrying the knife downwards in close contact with the bones, thus forms the anterior flap, taking care not to give it too great a degree of convexity. The posterior flap is made by drawing the knife across the back part of the limb, in a somewhat semilunar direction, the ends of the incision connecting themselves with those of the preceding one. The next step of the operation consists in dividing the ligaments which unite the radius and ulna to the humerus, and in sawing the olecranon process from before backwards, leaving all that portion which lies above the level of the joint, and which receives the insertion of the three-headed extensor muscle. It is

not necessary to interfere with the articular cartilage of the humerus, but it will improve the shape of the stump if the inner trochlea of that bone be cut off on a line with the other surface, as may usually be readily done in severing the olecranon.

The history of this operation is both curious and instructive. The first case occurred in 1536, in the hands of Ambrose Paré, in a soldier, who had been wounded in the forearm and made a rapid recovery. In 1671, it was performed, unsuccessfully, by Christian Ramphtun, a German military surgeon. After that period it was again practically lost sight of until 1819, when it was revived by Textor. In this country it was first performed in 1822, by Dr. Mann, of the Army, who was one of its most enthusiastic advocates, and whose patient made a good recovery. Dr. C. W. F. Uhde, of Brunswick, in 1865, furnished an analysis of 67 cases of this operation, including 2 by himself, of which 55 recovered, and 12 died. Of these cases, 31 occurred in the hands of Salleron, of Lyons, during the Crimean war, with a loss only of 5. The operation, in 47 of the cases, was performed on account of gunshot injury, and in the remainder for caries, fractures, and other lesions. Of 73 amputations at the elbow-joint for gunshot wounds, tabulated for this work, 25, or 34 per cent, were fatal.

AMPUTATION OF THE ARM.

In amputation of the arm, the same general rules are applicable, as it respects the point of election, as in the removal of the forearm, already described. The stump should be as long as possible; and the best covering for it is obtained by taking two flaps, one from the anterior and the other from the posterior aspect of the limb, the former being usually formed last, as it contains the brachial artery. The soft parts being firmly grasped, and held away from the bone, the transfixion is effected in the usual manner, the knife being carried downwards for a distance of two and a half to three inches, according to the dimensions of the limb, as shown in fig. 826. When the muscles are very large and firm, the surface of the flaps should be rather concave, to prevent redundancy of substance. The bone being sawed, the brachial artery and its branches are secured, and the flaps approximated by suture and plaster. The circulation of the limb, during the operation, is controlled by compression of the axillary artery, or of the subclavian above the clavicle.

Amputation of the arm by Teale's method is performed upon the same principle as amputation of the thigh. It is chiefly advisable in cases of injury attended with great loss of the soft parts. The ordinary flap and circular operations are generally preferable.

The statistics of this operation, for the relief of disease and ordinary accidents, are sufficiently flattering. Amputation of the upper arm in gunshot wounds is much more disastrous than resection of the elbow-joint for similar lesions. Of 3968 cases of the former, tabulated by Dr. S. W. Gross, 1202 proved fatal, while of the latter only 99 out of 499 died.

AMPUTATION AT THE SHOULDER-JOINT.

Of the numerous plans that have been devised for amputating the shoulder-joint, I shall content myself with an account of the following, an acquaintance with which will enable the surgeon readily to meet any emergency that may arise in practice, whether civil or military. In performing these operations, the circulation in the limb must be controlled by compressing the subclavian artery above the clavicle,

Fig. 826.



Amputation of the Arm.

either by means of the handle of a large key, or, what is much better, the compressor, described and delineated in the chapter on amputations, vol. i. p. 530. The head and chest should be well elevated by pillows, and the shoulder brought over the edge of the table, so as to allow the knife the most perfect freedom.

Amputation at the shoulder-joint is one of the most easy operations in surgery. Richerand long ago remarked that it might be performed with the same celerity

Fig. 827.



Larrey's Amputation.

Fig. 828.



Amputation at the Shoulder.

with which an adroit carver separates the wing of a partridge, and nothing is more true, although I have occasionally seen a case in which the surgeon consumed time enough not only to cut up the whole bird, but also to devour it.

1. One of the best methods of performing this operation is that of Baron Larrey, which consists in making two oval flaps, one in front and the other behind, as in fig. 827, each being from three to three inches and a half in length. The limb being held horizontally away from the body, with the hand in the prone position, the knife is introduced immediately beneath the acromion process of the scapula, and carried down through the centre of the belly of the deltoid muscle, for about two inches and a half, when, changing the line of direction, it is drawn around the upper extremity of the humerus, as far down as the centre of the axilla, the flap thus formed exhibiting a well-marked convexity in front. A similar flap is then made on the opposite side, when the elbow is carried forcibly backwards, behind the level of the trunk, to facilitate the disarticulation, which is effected by cutting closely from above downwards, around the margin of the glenoid cavity.

Instead of forming the flaps as here directed, they may be made by transfixion or cutting from within outwards, although the former is, on the whole, the better method.

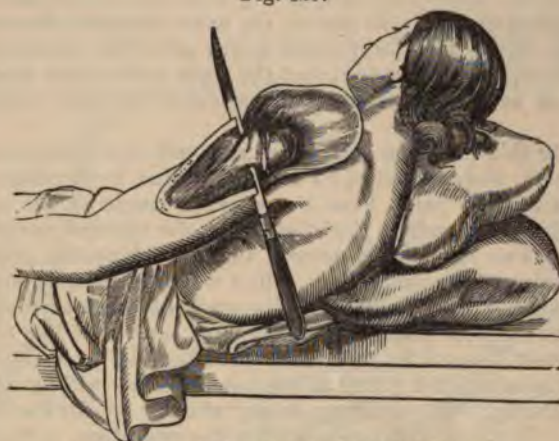
2. Supposing the left shoulder to be the subject of amputation, the knife is introduced at the inferior margin of the axilla, as in fig. 828, and brought out about half an inch

beneath the clavicle, just beyond the acromion process. By now drawing the instrument downwards, in close contact with the humerus, a large flap is formed, mainly at the expense of the deltoid and broad dorsal muscles. The capsular ligament being put upon the stretch by carrying the elbow across the front of the chest, disarticulation is readily effected, and the other flap formed by cutting the soft parts on the antero-internal portion of the limb, as in fig. 829. If the right shoulder be the seat of operation, the transfixion must be commenced above.

3. Lastly, an excellent stump may be formed by making the flaps at the outer and inner aspects of the joint. The elbow being elevated so as to depress the head of the humerus, and the cushion of the shoulder raised, the knife, supposing the left side to be the subject of the operation, is thrust in at the posterior margin of the deltoid and brought out at the anterior, the flap being formed almost exclusively of the substance

of that muscle. The soft parts being held up, the exposed joint is entered in the usual manner, and the other flap made at the expense of the structures in the axilla, by cutting from above downwards.

Fig. 829.



Amputation at the Shoulder, the Joint being Exposed.

It is proper to state that amputation at the shoulder-joint may be attended with the entrance of air into the veins of the axilla, as in the interesting case recorded by Roux, in which, almost before the disarticulation was completed, the man fell back dead upon the table. Such an event would be most likely to occur when there is great condensation of the surrounding tissues from inflammatory deposits favoring canalization of the veins.

The statistics of this amputation are less flattering than might have been anticipated from a consideration of the size of the articulation and the nature of the structures concerned in its execution. From the tables of Dr. Stephen Smith, published in 1853, it appears that, of 71 cases occurring in American and European hospitals, 34 proved fatal, thus showing a mortality of nearly 50 per cent. Of 788 operations on account of gunshot injuries, collected by Dr. S. W. Gross, 430 recovered, and 358, or 45.43 per cent., died. Of these, so far as could be ascertained, 178 were primary, with 46 deaths, and 95 were secondary, of which 61 were fatal, the mortality of the latter exceeding that of immediate amputation by 38 per cent. It is said that Larrey and his colleagues in the wars of Napoleon had amputated at the shoulder-joint in upwards of 100 cases, more than 90 of which recovered.

AMPUTATIONS ABOVE THE SHOULDER-JOINT.

Several instances have been recorded of recovery after the arm and scapula had been completely torn away by machinery; and surgeons, profiting by a knowledge of this fact, have not hesitated to remove these parts for the relief of injury and disease. In 1830 Gaetani Bey, of Cairo, successfully performed an operation of this kind upon a boy, fourteen years of age, on account of extensive laceration and fracture of the shoulder. After amputation at the glenoid cavity, the scapula was found to be much shattered, and was accordingly taken away, along with the projecting end of the clavicle. Professor Dixie Crosby, as he has kindly informed me, removed, in 1836, the entire superior extremity, including the scapula and clavicle, affected with osteo-sarcoma, the patient, a man thirty years of age, making a rapid and permanent recovery. The tumor measured thirty-seven inches in diameter. Two years later, Dr. George McClellan cut off the arm along with the scapula in a youth of seventeen, on account of an enormous encephaloid tumor. Very little blood was lost during the dissection, and the patient survived the operation upwards of six months, when he died from a recurrence of the disease.

Amputation above the shoulder-joint was successfully performed by Dr. Mussey, in 1845, on account of osteo-sarcoma. The removal included the entire scapula, the arm, and the outer half of the clavicle. A similar operation was performed, in 1846,

by Dr. Gilbert, of this city, upon an elderly gentleman, the subject of a large encephaloid growth of the shoulder. In this case, however, only a portion of the scapula was taken away. The patient recovered from the immediate effects of the operation, but died some months afterwards from a return of the malady. Sir William Fergusson has twice removed the upper extremity along with the scapula and a portion of the clavicle for malignant disease. In one of the cases complete recovery followed; in the other the man died within forty-eight hours after the operation. Mr. Vincent Jackson, of England, in 1864, amputated the right arm at the shoulder-joint along with the scapula on account of injury, the patient dying from exhaustion the next morning.

In amputating in this situation the surgeon should take care, first, to save a sufficiency of integument, and, secondly, to prevent undue hemorrhage. The incisions should extend, on the one hand, from the superior angle of the scapula along the upper border of that bone, and, on the other, from the anterior surface of the clavicle, nearly as far inwards as its middle, around the shoulder-joint, and thence down to the inferior extremity of the scapula, in a line with its axillary margin. The flaps thus marked out should then be rapidly dissected up, with as much soft substance as possible, and the different muscular connections severed. The collar bone should be sawn through near its middle, but not until after the separation of the scapula, as the weight of the arm, by drawing down the shoulder, will greatly facilitate this step of the proceeding. The axillary artery should be divided last, and should instantly be tied. If the tumor, necessitating the operation, is uncommonly bulky, it might be well to secure the subclavian as a preliminary step, but this will seldom be required.

After the bleeding has ceased, the wound is closed in the usual manner, and every effort is made to insure its rapid healing. The lungs should be watched with special care.

2. INFERIOR EXTREMITY.

In performing the more important amputations of the inferior extremity, the circulation is usually most effectually controlled by compression of the femoral artery, in the upper portion of its course, by means of the tourniquet, or, if the patient is very thin, by the fingers of a trustworthy assistant, against the pubic bone. In removing the foot and lower part of the leg, the compression may be applied to the popliteal artery. In describing amputation at the hip-joint, special mention will be made of the manner of preventing hemorrhage in that operation. When recourse is had to the tourniquet, the surgeon takes care, before applying the instrument, to elevate the limb, and to press the blood out of the superficial veins from the heel upwards. This precaution is particularly important in weak, anemic subjects, in whom the loss even of a few ounces of blood is often followed by the most serious consequences.

AMPUTATION OF THE FOOT.

The toes are never removed in their continuity or at the phalangeal articulations, inasmuch as the stump thus left would only be in the way of the patient, and thus occasion serious inconvenience, if not positive suffering, from being constantly impinged upon by the shoe or boot. It is for this reason that the operation should always be performed at the metatarso-phalangeal joints; and this may be readily done, when all the toes are involved, as, for example, in gangrene and frost-bite, by taking the principal flap from the plantar aspect of the foot. The amputation is commenced by making an incision across the back of the limb, from one side to the other, immediately in front of the metatarso-phalangeal articulations, which, the integument having been dissected up, are then entered with the knife, an ordinary narrow-bladed scalpel, and successively divided from above downwards, the operation being finished by carrying the instrument forwards to a level with the web of the toes, in order to obtain a sufficiently large covering from the sole of the foot. There is no necessity for cutting off the ends of the metatarsal bones. Any bleeding vessel that may exist being ligated, the plantar flap is stitched in place, and maintained by adhesive strips, aided by an appropriate bandage.

When only one of the smaller toes is to be removed, the operation should be performed with oval flaps, fig. 830, as in amputation of the fingers at the metacarpo-

phalangeal articulation. The disjunction will be facilitated by forcibly flexing the toe. The extensor tendon should be divided above the joint.

Fig. 830.



Amputation of the Toe at its Metatarso-phalangeal Joint.

Fig. 831.



Amputation of the Big Toe through the Metatarsal Bone.

When the small toe is removed, whether alone, or along with the adjoining one, the stump will be much more seemly, as well as more useful, if a small portion of the corresponding metatarsal bone be cut off, so as to give the part a sloping appearance, as in one of my cases at the Philadelphia Hospital. In the ordinary operation the stump is very angular, and the consequence is that it is constantly irritated by the pressure of the shoe.

When the *great toe* requires removal, the operation should be performed through the continuity of the metatarsal bone, and not at the metatarso-phalangeal articulation, as in this case the large head of the metatarsal bone would sadly interfere with the wearing of the boot. Two incisions are made along the dorsum of the foot, commencing at an acute angle a short distance in front of the internal cuneiform bone, passing around each side of the toe anteriorly to the joint, and terminating at the centre of the web which connects the big toe with the adjoining one. The soft structures being carefully detached, the metatarsal bone is sawn through in a sloping direction, including fully one-half of its length. The sesamoid bones are removed along with the flexor tendon of the toe. The wound usually heals very promptly, and the cicatrice, corresponding with the dorsum of the foot, is seldom productive of inconvenience when the patient begins to walk, especially if proper attention has been paid during the operation to the preservation of the integument. The appearance of the parts is well shown in fig. 831, representing the approximation of the wound by suture.

Removal of the entire metatarsal bone is effected with a large flap, extending from a little in front of the metatarso-phalangeal joint to a few lines beyond the internal cuneiform bone.

The foot is sometimes removed at the *tarso-metatarsal* junction. The operation, however, is seldom practised, as it is rare that the diseases and accidents requiring such a procedure are confined entirely to the metatarsal bones; besides, such is the manner in which these pieces are connected to each other and to the tarsal bones that it is one of unusual difficulty.

Fig. 832.



Appearance of Parts after Amputation of the Big Toe with its Metatarsal Bone.

When deemed necessary, it should be executed according to the plan originally suggested and described by Mr. Hey, of Leeds, in his *Practical Observations on Surgery*. The operator, taking the tubercle of the fifth metatarsal bone and the projection of the scaphoid as his guides, forms a large convex flap on the plantar surface of the foot, by carrying his knife as far forwards as the ball of the toes. In order to give more precision to his incision, a line may previously be traced in ink across the foot, along which the knife is then passed in the transfixion; or, what is preferable, the flap is made by cutting from without inwards, and from before backwards. The latter is the method which I generally adopt, because it enables us to give the flap a rounder and smoother shape, thereby avoiding the necessity of trimming it after the operation is completed, as is usually the case when performed in the ordinary way.

Fig. 833.



Hey's Amputation.

The dorsal flap, represented in fig. 833, is comparatively small, and is composed entirely of integument; it is slightly convex, and is easily made with a large scalpel. The soft parts being dissected up, each joint is entered separately, the disarticulation being expedited by bending the anterior extremity of the foot forcibly backwards. In executing this step of the operation, it is important to remember the oblique shape of the fifth metatarsal bone, at its articulation with the cuboid, and the peculiar manner in which the head of the second metatarsal bone is locked in between its fellows, as well as the distance to which it projects behind the level of the tarso-metatarsal junction. Owing to these circumstances, it is generally extremely troublesome to disengage it; and hence it is

always best to leave it, by sawing through its body on a line with the other joints. The stump, after removal of the parts, in Hey's operation, is seen in fig. 834. The plantar and dorsal arteries being secured, the flaps are carefully adjusted, and the limb is supported, in an easy and relaxed position, upon its outer surface, to counteract the action of the gastrocnemial muscles, which might otherwise draw the foot out of place.

Fig. 834.



Stump after the Removal of the Parts, in Hey's Operation.

In caries, as well as in injury of the metatarsal, cuneiform, cuboid, and scaphoid bones, the foot may occasionally be removed in such a manner as to leave merely the astragalus and calcaneum, the principal flap being obtained from the sole. The operation is usually known as *Chopart's amputation*, but the name of Mr. Syme is also generally associated with it, as he was the means of reviving it by recalling to it the attention of the profession in Great Britain and this country. Of the utility of this procedure in the class of cases under consideration, there can be no doubt; I myself have not only employed it several times, but have seen it repeatedly executed by others, and, in almost every instance that has come within my notice, the result has been most satisfactory. The stump, although short, is extremely useful, affording an admirable support for the limb, the person generally walking well without the assistance of a cane. In one of my cases, the individual, a young countryman, was able, in less than six months after

the operation, to plough and do all the usual work of a farm hand with the greatest facility and comfort.

In performing the operation a short flap is made in front of the foot, by an incision extending around its dorsal surface, from one side of the member to the other, in a curvilinear direction, the convexity looking forwards, as in fig. 835. It should begin precisely midway between the outer malleolus and the head of the fifth metatarsal bone, which indicates the site of the calcaneo-cuboid articulation, and terminate on the inner margin of the foot, directly opposite, at the astragalo-navicular articulation. The integument being dissected up, the blade of the knife, which should be sharp-

Fig. 835.



Chopart's Amputation.

Fig. 836.



Stump after Chopart's Amputation.

pointed, and at least six inches in length, by half an inch in width, is thrust into the two joints just mentioned, and, being brought out below, is next carried forwards, in close contact with the bones, as far as the ball of the toes, in order to form the inferior and main flap. The only arteries which usually require to be tied are the dorsal and two plantar. The extremity of the plantar flap should be well rounded off before it is stitched to the dorsal, and during the cure special care should be taken to keep the gastrocnemial and other flexor muscles completely relaxed, by placing the leg upon its outer surface over a pillow. From neglect of this precaution the stump is liable to be retracted, so that the cicatrice, by constantly coming in contact with the ground, is apt to ulcerate and cause severe suffering. If such a contingency should arise, the proper remedy will be the subcutaneous division of the tendo Achillis; an operation which need never be performed in anticipation of this occurrence, since it may always be effectually avoided by taking the requisite care during the after-treatment. The adjoining drawing, fig. 836, taken from life, exhibits the ordinary appearances of the stump.

It is not always easy to hit the two joints concerned in this operation. The effort will be most likely to succeed if, after the anterior flap has been sufficiently raised, the foot be placed at a right angle with the leg, and the point of the knife be inserted about one inch in front of the tibia.

AMPUTATION AT THE ANKLE.

Although amputation at the ankle-joint has long been known to the profession, yet the credit of popularizing it is justly due to the teachings and influence of Professor Syme, who first performed it in 1842. He afterwards repeated it upwards of thirty times, and his example has now been so frequently followed by others, in America as well as in Europe, that it may be regarded as one of the established operations in surgery. I performed it for the first time it was ever done in this country, in 1851, with the aid of Professor Pattison, in the presence of the medical class of the New York University, upon a young woman, affected with extensive caries of the tarsal bones. She made a good recovery, but the disease subsequently broke out in the tibia, and necessitated the removal of the leg. A brief abstract of the case was published at the time in *Reese's Medical Gazette*. Less dangerous than amputation of the limb in its continuity, the operation is particularly adapted to cases of caries of the posterior tarsal bones, especially of the astragalus and calcaneum, without any involvement of the ends of the tibia and fibula. When such a complication exists, except in a very slight degree, the limb should be taken off higher up, otherwise it will be difficult, if not impossible, to prevent a recurrence of the disease.

Syme's amputation—for so this operation is now generally distinguished—is performed with two flaps, one of which is taken from the front and the other from the sole of the foot, the two meeting at the outer and inner ankle. The best instrument is a large scalpel; the foot is placed at a right angle with the leg, and the circulation is controlled by means of the tourniquet applied to the femoral artery. The operation is commenced by making a perpendicular incision from the centre of one malle-

olus to that of the other directly across the sole of the foot, and then carrying another, of a curvilinear shape, with the convexity looking forward, over the fore part of the limb, so as to join the two points of the former at an angle of 45° . The lines of these cuts are well seen in fig. 837. The anterior flap is now carefully raised, the astragalus disarticulated, and the posterior flap dissected off from the calcaneum, by passing the knife closely over its surfaces, as in fig. 838, in order to avoid wounding

Fig. 837.



Amputation at the Ankle-joint.

Fig. 838.



Mode of Removing the Calcaneum in Syme's Amputation.

Fig. 839.



Stump after Syme's Operation.

the tibial artery. The tendo Achillis being severed from its connections, the operation is finished by sawing away the two malleoli and a thin slice of the tibia, just enough to include its cartilaginous incrustation. The posterior flap thus formed, consisting of the thick and hardened cushion of the heel, affords an admirable covering for the exposed bones, to which it usually unites by the first intention, and which afterwards enables them to bear pressure with great facility. The only objection to it is that, unless special care be taken in its adjustment, it may form a sac for the accumulation of matter, thus greatly retarding the cure. This, however, is generally easily prevented by the proper application of the bandage in dressing the stump at and for some time after the operation. Should this contingency, however, arise, relief must be afforded by a small puncture through the plantar surface of the flap. The appearance of the stump, after the parts are healed, is shown in fig. 839.

In performing this operation there are three points deserving of special attention. The first is not to have a redundancy of flap, as will seldom happen if they are both shaped in the manner here described; the second is not to cut any holes into the posterior flap while severing its connections with the calcaneum; and the last is not to divide the posterior tibial artery prior to its separation into its plantar branches, otherwise sloughing of the soft parts might ensue from deficient nourishment. If these precautions be observed, it will be difficult to make a bad stump. When the cure is completed the limb will be from an inch to an inch and a half shorter than natural.

When, from disease, or injury, the flaps cannot be formed according to the plan now laid down, they may be taken from the sides of the limb, including as much of the integument of the heel as possible. The operation is easy enough of execution, but the cicatrice after the healing of the stump will be much in the way of the patient's comfort, and may lead to the necessity of amputating higher up.

Of 219 cases of this operation, collected in 1866, by Mr. Henry Hancock, 17 died, 13 underwent secondary amputation, of 6 the result is unknown, and 183 recovered so completely as to be able to walk well. All the cases occurred in civil practice, the amputation having been performed in nearly three-fourths on account of caries.

The operation of Mr. Syme was modified in 1852 by Mr. Pirogoff, of Russia, by retaining a portion of the calcaneum, and thus imparting greater length and rotundity to the stump. It is performed as in the ordinary disarticulation of the ankle,

by making a curvilinear incision around the foot in front, and a perpendicular one under the sole, extending from the fore part of one malleolus to that of the other. The anterior flap being dissected up, the knife, a short, stout bistoury or scalpel, is introduced into the joint, so as to divide the different ligaments, and detach the astragalus. The saw is now applied just behind the astragalus, and moved obliquely downwards and forwards, in order to separate the anterior portion of the calcaneum, as seen in fig. 840. The operation is completed by removing the two malleolar projections, along with a thin layer of the articulating extremity of the tibia, tying the vessels, and stitching the flaps accurately together.

The advantages of this procedure are that it affords not only a longer stump, but one that is better adapted to bear pressure, that there is no danger of wounding the posterior tibial artery, and that the posterior flap is not so liable to form a pouch for the lodgment of pus. Its disadvantages are the tardiness of the cure, and the fact that the disease necessitating a resort to the knife may recur in the retained portion of the bone. The latter objection does not, of course, apply with equal force when the operation is performed on account of injury. When the dressing is completed, the upper surface of the calcaneum is in immediate contact with the lower surface of the tibia and fibula, to which it gradually unites by osseous matter.

In operating upon the cadaver, I have ascertained that an excellent stump may be made by bringing the wedge-shaped portion of the heel-bone up between the malleolar processes of the tibia and fibula, their cartilaginous surfaces being previously well abraded. It is worthy of consideration whether the parts, if thus treated upon the living subject, would not afford a better support for useful progression than the ordinary procedure.

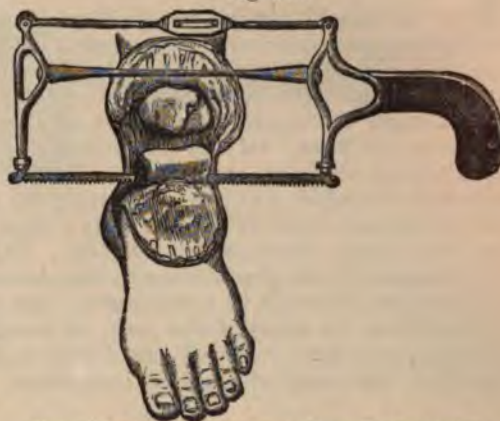
Several modifications of this operation have been proposed; as that of Bontecou, of making the plantar flap from within outwards by carrying the incision from the posterior border of one malleolus to the other; of Pirrie, of sawing the calcaneum from below upwards instead of from above downwards; and that of cutting off the projecting ends of the tibia and fibula before disarticulating. I am not aware, however, that any material advantage is gained by any of these procedures.

Of 58 cases of this amputation, collected by Hancock, from the practice of British surgeons, 5, or 8.62 per cent., terminated fatally. Suppuration in the course of the tendons was observed in 11, 5 suffered secondary amputation, and 43 recovered with useful stumps. Of the latter 25 were performed for caries, and 18 for accidents. When the cure is completed, the patient is generally able to walk without the aid of a cane, the limb being not more than about half an inch shorter than in the natural state.

A very long, useful and seemly stump may sometimes be formed by removing the foot with all the tarsal bones, excepting the astragalus, although such a procedure cannot often be required, inasmuch as this piece is usually diseased along with its fellows. The operation, denominated the *subastragalar amputation*, is performed in the same manner as that of Syme. After the soft parts have been dissected up, the scaphoid and calcaneum are detached from their connections with the astragalus, the bistoury being passed between their contiguous surfaces. The plantar arteries are cut long, to prevent sloughing of the heel flap.

My opinion of the usefulness of the stump left by these different operations at and near the ankle joint is not, from what I have seen of it, very favorable. It may answer very well when the patient is wealthy; but if he be poor, and obliged to work for his daily subsistence, he will generally get along much better with an artificial limb than with a stump that affords, even under the most propitious circum-

Fig. 840.



Mode of Sawing the Calcaneum in Pirogoff's Amputation.

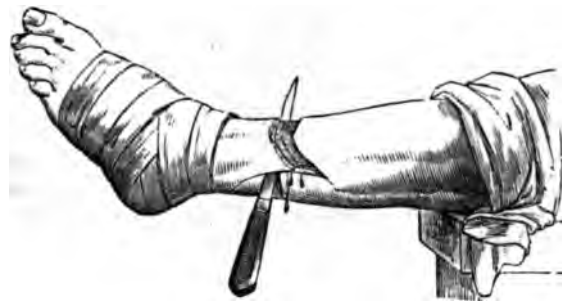
stances, only a very miserable basis of support, and from the slightest causes, to pain, irritation, and ul

AMPUTATION OF THE I

The leg should always, if possible, be amputated about three inches or three inches and a half from the rule is to afford the patient a long stump, for artificial limb. Moreover, statistics serve to show that amputation when performed here is remarkably small approach the knee. Of 106 amputations of the leg the Parisian surgeons, only 13 proved fatal. The operation is chosen in the injury or disease requiring the operation for choice, and hence we are generally obliged to cut up than would otherwise be desirable. The mode of amputation must necessarily vary according to the portion of the leg to be removed.

When the operation is performed in the inferior third of the leg, the incision is formed from the sides of the limb, by cutting from the heel to the toes, and the flaps are turned out of this, one may be made in front, and the other in back, as in fig. 841. Composed entirely of integument in front

Fig. 841.



Amputation of the Leg at its Inferior Third.

quantity of muscular substance behind, and should each be from two inches to two inches and a half length. The interosseous tissues are divided on a level with the retracted flaps, and the two bones are sawn in such a manner as to sever the fibula before the tibia. Three principal arteries usually require the ligature. The edges of the wound are approximated vertically, to facilitate drainage. Fig. 841 exhibits the shape of the stump as obtained from a sketch from life.

The circular operation makes an excellent stump when the leg requires removal in the lower third of its length; I have practised it in a number of instances with the most gratifying results, the persons being able to walk with the aid of an artificial limb. In the exception of the bones became necrosed some days after the operation, some defect of the constitution, which ultimately caused the eversion of the flap in this operation will be grasped as sometimes happens, the parts are oedematous, and the stump is on its inner or outer surface.

Teale's operation, fig. 843, is not often performed, but it affords a useful and seemingly permanent stump. The outlines of the leg are marked, and the lateral incisions are made first through the skin, and then through the bones. The long flap, consisting of all the integument and the fibula, is then dissected up, after which the short portion of the tibia is removed from the bones and interosseous ligament.

the saw is to be applied. The anterior tibial vessels, cut only once, are included in the anterior flap. The long flap, instead of being made in front, may occasionally be advantageously made behind.

Amputation of the leg at its superior extremity should never be performed above the tubercle of the fibula, or above the attachments of the hamstring muscles, which are so necessary to control the movements of the stump. The stump should generally be at least three inches in length, otherwise it will hardly be able to subserve any useful purpose, and it would be better, in such a case, to remove the limb at the knee. Two flaps are formed in this operation; one, which is entirely cutaneous, in front, by cutting from without inwards, and the other behind, at the expense of the muscles of the calf, by cutting from within outwards, as seen in fig. 844. The latter should not be less than four inches in length, and, in very robust subjects, may even require to be longer. The anterior flap is formed by making a semilunar incision across the front of the limb, from the inner edge of the tibia to the outer edge of the fibula; it is detached by a few strokes of the knife, and held up by an assistant. The instrument is then inserted at the external angle of the preceding cut, and brought out at the corresponding point of the opposite side, care being taken, in performing this part of the operation, not to thrust the extremity of the knife between the two bones; an occurrence which always betrays haste and embarrassment, if not actual want of anatomical knowledge. Transfixion being effected, the knife is drawn rapidly downwards, in close contact with the posterior surface of the bones, for the distance of several inches, when it is made to cut its way out, in order to give the flap a proper degree of convexity. As soon as this has been accomplished, the flap is retracted by the assistant, the interosseous structures are divided at the requisite height, and the two bones are sawn in such a manner as to sever the fibula before the tibia. The principal arteries will next claim attention, and it will generally be found that three—the anterior and posterior tibial, and interosseous—will require to be tied. When the amputation is performed very high up, the popliteal may be the only vessel demanding ligation, especially if it extend unusually far down before it separates into its terminal branches.

The next step of the operation is the retrenchment of the posterior flap by shaving off its redundant muscular substance, so as to adapt it more smoothly and accurately to the exposed bones. I consider this procedure as indispensable to the obtainment of a good, seemly, and useful stump, and, as the patient is in a state of anæsthesia during its execution, it cannot be a cause of suffering. I rarely allow the flap to be more than half an inch in thickness. Any considerable nervous trunk that may exist in the flap is now divided on a level with the bones, and the operation is completed by sawing off the anterior edge of the tibia, lest, if permitted to remain, it should interfere with the healing of the wound, or, in time, cause so much pressure as to induce ulceration in the cicatrice.

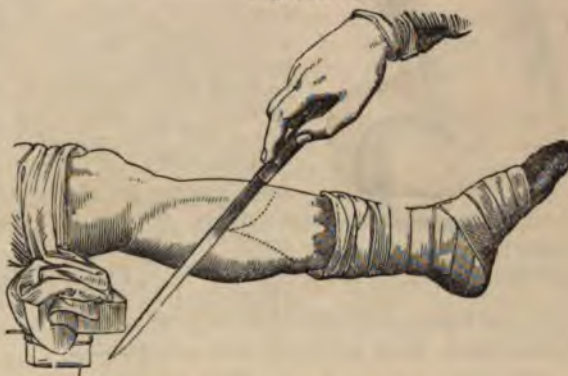
Great annoyance is often experienced in this operation in securing the arteries, espe-

Fig. 843.



Teale's Operation.

Fig. 844.



Amputation of the Leg above its Middle.

cially the anterior tibial when it has been divided immediately after its passage through the interosseous ligament. The short stump thus left is sure to retract and bury itself among the surrounding structures in such a manner as to render it very difficult to seize and ligate it. A long time is occasionally consumed in fruitless efforts of this kind, the vessel, perhaps, in the meanwhile bleeding very freely. A good plan is to detach the parts in which it is contained from the surrounding structures, and to include them all in one ligature, drawn with more than ordinary firmness; or, what is far preferable, to apply an acupressure needle, as this can always be removed within forty-eight hours after the operation. It is usually in vain to attempt to draw out the artery with the forceps or tenaculum; indeed, even if this could be done, it would be extremely difficult, if not impossible, to tie the ligature sufficiently tight to enable it to hold its place until a sound, adherent clot has formed.

The bleeding from the nutrient artery of the tibia generally soon ceases of its own accord. Should it prove troublesome, it may readily be arrested by plugging the foramen through which it passes with a piece of soft wood, or, what is better, a little slip of periosteum.

Fig. 845.



Stump after Amputation of the upper part of the Leg.

During the after-treatment the limb should be constantly maintained in the extended position, by means of a well-padded posterior splint, otherwise the stump will be permanently retracted by the action of the hamstring and gastrocnemial muscles, so as to interfere materially with the use of an artificial substitute. Should such a contingency occur, despite the best directed efforts of the surgeon, relief must be sought in tenotomy and passive motion, conjoined, if need be, with suitable apparatus to reclaim the functions of the knee-joint. The appearance of the stump, made after the above fashion, is represented in fig. 845, from one of my patients.

Amputation at the middle of the leg is performed in the same manner as at the superior extremity, and does not, therefore, require any special notice. It is proper, however, to add that a very good stump may be formed by taking the flaps from the sides, as in the lower operation, although I have always preferred the other method.

Of 4011 amputations of the leg on account of gunshot injury, tabulated by Dr. S. W. Gross 1366 or 34 per cent., were fatal.

AMPUTATION AT THE KNEE-JOINT.

Amputation at the knee-joint was originally performed by Fabricius Hildanus in 1581. In modern times it is said to have been first executed by Hoin, and, although his example was soon after followed by several of his contemporaries, yet the operation gradually fell into neglect, chiefly, it would appear, because of the timidity of surgeons to meddle with the large articulations. An attempt to revive the procedure, accompanied by a report of a number of successful cases, was made by Velpeau in 1830, but with so little effect that the subject was again forgotten, and the operation proscribed from our systematic treatises until a few years ago. Since then much has been urged in commendation of it, especially by Dr. Markoe, of New York, and Dr. Brinton, of this city, and, judging from the success which has attended it, both in this country and in Europe, it may now be regarded as an established fact. The first amputation at the knee-joint, in America, was performed, in 1824, by Professor Nathan Smith, of New Haven, the patient recovering without any untoward symptoms.

The reasons which may be alleged in favor of this operation are, first, that the stump, being longer than in amputation of the thigh in its continuity, is more under the control of the patient, and, consequently, better able to bear the weight of the body upon an artificial limb, thus permitting progression without the aid of crutches; secondly, that, as there is no retraction of the muscles, there is less risk of exposure and exfoliation of the bone; thirdly, that the liability to pyemia is generally diminished from the fact that there is no injury inflicted upon the medullary canal; fourthly, that the wound is less than in the removal of the limb in its continuity; and, finally, that the statistics of the operation exhibit a smaller rate of mortality

than amputation of the thigh. It need hardly be stated that disarticulation of the knee should never, as a matter of choice, be performed in preference to amputation of the leg in its continuity; such a procedure, involving more risk to life than the other, would not be justifiable; for, as remarked elsewhere, the nearer the knife approaches the lower part of the trunk the greater is the mortality from its effects.

There are two principal methods of performing this amputation, the relative merits of which have not yet been fairly determined by statistics. The one consists in making a long flap in front, the other in making it behind, at the expense chiefly of the gastrocnemial muscles. Both operations are sufficiently easy, but when the surgeon has his choice he will, I think, be able to effect a more rapid cure, as well as make a better stump, by adopting the former procedure.

In the anterior operation, as it may be called, the knife is carried across the forepart of the leg, at least two inches and a half below the head of the tibia, in a semi-lunar direction, from the anterior margin of one hamstring muscle to that of the other; the flap is then carefully raised, the ligament of the patella divided, the disarticulation effected from before backwards, and the posterior short flap formed from the superior extremity of the gastrocnemial muscle, care being taken to preserve as much skin as possible. The patella, completely denuded of cartilage, is retained to fill up the gap between the two condyles, and thus add to the rotundity of the stump. Another advantage is that the line of the wound, after the approximation of the flaps, is brought into a more dependent position, thereby admitting of the more ready exit of the discharges.

Great care should be taken during the after-treatment that the patella is not drawn up by the action of the extensor muscles. Should such a tendency arise, it will be best counteracted by flexing the thigh strongly upon the pelvis, aided, if this be insufficient, by the subcutaneous division of the extensor tendon.

In the posterior process, the principal covering of the bone is obtained from the muscles of the calf of the leg. The operation is commenced by drawing the knife across the centre of the patella, from one side to the other, the articulation being fully opened at the first incision. The integument is then dissected off from the patella, as high up as the superior extremity of this bone, which is next liberated from its tendon, and left adherent to the tibia. Introducing now the knife into the joint, the connecting structures are rapidly severed, and the main flap formed by carrying the instrument downwards, to a suitable distance, behind the bones. The operation is completed by removing the condyles of the femur, the saw being held in such a manner as to separate a larger portion of the inner than of the outer of these prominences, so as to give the stump a perfectly horizontal direction. Or, what is preferable, because less likely to be followed by suppuration and other mischief, while the stump is equally good after the cure, the condyles, unless diseased, are left intact, the flaps being brought in direct contact with their articulating surfaces.

A very excellent stump may be formed in this amputation by covering the end of the bone with a single flap of integument taken from the front of the anterior surface of the leg. The procedure is best adapted to those cases in which the condyles remain intact. The flap should be of a semioval shape, and should embrace as large a quantity of cellulose-adipose tissue as possible. In the operation of Mr. Carden, of Worcester, England, the flap, composed solely of tegumental material, is raised in front of the joint, of sufficient length and width to fall over the stump in the form of a hood. The soft structures are divided all around straight down to the bone, which is then sawed off a little above the plane of the muscles, in such a manner as to include the condyles without laying open the medullary canal. The patella is also removed. The only objection to this operation is that there is not always a sufficiency of substance on the back part of the limb. To remedy this defect a short posterior flap, slightly convex, and composed exclusively of integument, may be made, as suggested by Mr. Joseph Bell, of Edinburgh. Mr. Carden, up to 1864, had performed this operation thirty times; in seven cases for injury with six cures, and in twenty-four cases for disease with a loss of four.

Dr. William Stokes, of Dublin, has several times performed what he calls the supracondyloid amputation of the thigh, differing from that of Mr. Carden, chiefly in that the bone is sawed off above the condyles, from half to three-quarters of an inch beyond the anterior superior edge of the cartilage of incrustation, and yet sufficiently low to prevent exposure of the medullary canal. The anterior flap is

oval, not rectangular, and two-thirds longer than the posterior. The patella, denuded of cartilage, is placed in even contact with the extremity of the femur, thus preserving the attachment of the four-headed extensor muscle.

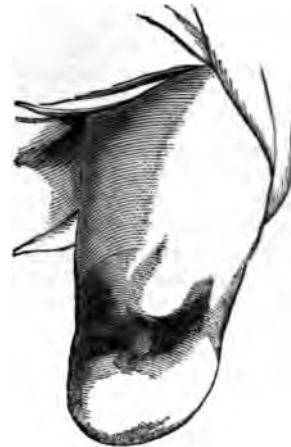
Professor Stephen Smith, of New York, strongly advocates the employment of lateral flaps, on the ground of more easy drainage, and less danger from pressure of the stump in progression from the artificial limb. The operation is performed by carrying two incisions, commencing about one inch below the tubercle of the tibia, downwards and forwards over the most prominent part of the side of the leg, until they reach the posterior surface, when they are curved towards the middle line, and then continued directly upwards to the centre of the joint. The flaps are entirely tegumental, and the internal one may be a little longer and fuller than the outer, so as to form a thorough covering for the corresponding condyle of the femur. The patella is retained, and the ligatures are brought out at the posterior angle of the wound. In addition to the advantages above referred to, this amputation recommends itself by its simplicity and the facility of its execution. The adjoining cuts, figs. 846 and 847, afford good illustrations of the appearance of the flaps and of the stump after the completion of cicatrization.

Fig. 846.



Amputation at the Knee with Lateral Flaps.

Fig. 847.



Appearance of the Stump in Smith's Amputation.

Professor Pancoast has, on several occasions, performed amputation at the knee-joint with three flaps; an anterior, semilunar in shape, with the convexity extending three inches below the tuberosity of the tibia, and two posterior lateral ones, much shorter, and well rounded off. The patella is retained, and the entire operation may be performed with the scalpel.

In young subjects, prior to the age of puberty, the limb may sometimes be advantageously severed at the junction of the epiphysis with the shaft of the bone instead of at the knee-joint, the surgeon thus avoiding all risk of pyemia and osteomyelitis. Disunion is effected by gentle force, conjoined, if necessary, with the use of the knife, the employment of the saw being prejudicial. The end of the bone, rounded and nodular, bleeds hardly any, and leaves a stump well suited for the adjustment of an artificial leg. The great objection to this operation is its liability to interfere with the subsequent growth of the limb.

After these various operations the popliteal artery, and generally also several of its branches, will require ligation. The popliteal vein often bleeds profusely, either because of the pulsation imparted to it by the accompanying artery, or because of the unyielding nature of the tissues in which it is embedded, and should, in such an event, be at once tied. In the operation by the long posterior flap, the union of the wound will be greatly expedited by bringing the ligatures out through a small orifice at the centre of the flap. Whatever method of operation be selected, there are three points in amputations of the knee-joint worthy of special consideration, an abundance of integument, the retention of the patella, and accurate union of the wound.

The patella, inserted into the hollow between the condyles, soon becomes ankylosed, and adds greatly to the beauty and value of the stump.

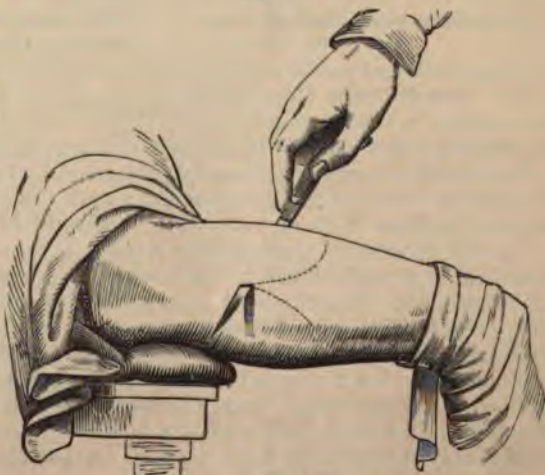
Of 164 cases of amputation at the knee-joint, tabulated in 1868 by Dr. John H. Brinton, 53 were fatal, the mortality being about 32 per cent., or, in other words, from one-fourth to one-sixth less than in amputation of the thigh in its continuity. Of these cases 117 occurred in America and 47 in Europe, with a remarkable similarity in regard to the death rates. In 79 cases in which the condyles of the femur were left intact the percentage of mortality was 27.84, and in 32 cases in which they were removed 28.12. The loss attendant upon 59 primary operations for injury was 42.37 per cent., and 37.83 per cent. in 37 secondary cases. In 62 pathological operations, the mortality was only 22.58 per cent., thus showing a marked advantage over the traumatic. The average death rate of all cases of amputation at the knee-joint in the military practice of this country during the late war was about 50 per cent. Of 1597 cases of amputation of the thigh in its continuity performed during the same period, in the Army, 1029 terminated fatally, affording a death rate of 64 per cent. Of 246 operations for gunshot injury, analyzed by Dr. S. W. Gross, 172, or 69 per cent., perished.

AMPUTATION OF THE THIGH.

The thigh may be removed in any portion of its length; at its inferior third, at its middle, at its superior third, or at the hip-joint, according to the particular exigencies demanding the operation. The great general rule, mentioned elsewhere, of leaving as long a lever, in all cases, as possible, is still more applicable here than in the leg and arm; experience having shown that it is extremely difficult to adapt a short stump of the thigh to an artificial limb, especially when, as not unfrequently happens, it is at the same time very bulky. The operation which I have always performed, and which, in my judgment, is decidedly the best, is that by flaps, taken from the anterior and posterior parts of the thigh. I have seen enough of the circular method to satisfy me that it is, as a rule, even when well executed, very objectionable, on the ground that, as it seldom affords an adequate covering for the stump, it is so often followed by exfoliation of the bone, tedious suppuration, and ulceration of the integument. From these mishaps the flap amputation is almost entirely exempt. It can not be denied that admirable results are occasionally witnessed from the circular operation, but that it is more liable to be followed by accidents and by future inconvenience and suffering is unquestionable, and it is for these reasons, and not because it involves any particular difficulty or skill in its execution, that it should give place to the flap method.

Although the operation by the antero-posterior flap usually furnishes the best result, from the circumstance that there is less liability to retraction, yet a very excellent stump may be made by taking the covering from the sides of the limb, or even by dividing the parts obliquely. The fact is, the surgeon has often no choice in the matter, such being the nature of the disease or injury demanding the operation. In a case of horrible deformity and ulceration of the leg, from the effects of a burn, followed by permanent ankylosis of the knee-joint, under my observation, many years ago, in a boy five years of age, I was obliged to depend entirely upon one flap taken from the posterior surface of the thigh, with a result that could not possibly have been more satisfactory. Whenever circumstances require a departure from the ordinary rules of procedure,

Fig. 848.



Amputation of the Thigh.

the educated surgeon will have no difficulty in adapting his skill to the exigencies of the case.

The lowest point at which amputation of the thigh can conveniently be performed is about four inches above the centre of the knee. The anterior flap should always be made first, as the posterior includes the femoral artery. The soft parts being forcibly raised with the thumb and fingers, applied to the opposite sides of the limb, the knife is entered about three inches above the superior extremity of the patella, and, transfixion being completed, is drawn downwards close along the anterior surface of the femur, cutting its way out at the point just mentioned. The flap being now carefully retracted, the instrument is reintroduced into the wound at its upper edge, behind the bone, so as to fashion the posterior flap, which should be somewhat longer than the anterior, otherwise there will be danger of insufficiency of covering. This flap is now also held back, when, the knife being passed rapidly around the bone, on a level with the retracted structures, so as to divide any muscular fibres that may have escaped it in the previous stages of the operation, the bone is sawn off in the usual manner. The femoral artery with several of its branches will require ligation, and the principal nervous trunks should be retrenched before approximating the flaps.

The stump left by the flap operation, as here detailed, is a very pretty one, and could not possibly be more serviceable. The drawing, fig. 849, is from life.

Fig. 840.



Stump after Amputation of the Thigh.

The operation now described may occasionally be advantageously executed, according to Vermale's method, by lateral flaps, of which the outer one should always be formed first. The transfixion is effected at the same height of the limb as in the preceding case, that is, from three to four inches above the upper extremity of the patella, the knife being inserted at the centre of the thigh in front, and pushed out at a corresponding point in the ham, whence it is carried downwards and outwards nearly as far as the external condyle. The inner flap is formed in the same manner, except that the instrument is kept in closer contact with the bone, lest the femoral artery be split. In other respects, the operation is to be conducted in the same manner as in the antero-posterior flap procedure.

In the middle and upper third of the thigh, the method by anterior and posterior flaps deserves a decided preference over that by lateral flaps. The great advantages which it possesses over the latter are that the muscles are more evenly divided, and that, consequently, there is greater probability of obtain-

ing a smooth and useful stump for sustaining the weight of the body upon an artificial limb. The different steps of the operation are similar to those which characterize amputation in the lower third of the thigh, and hence there is no necessity whatever for any formal description of it, as they will be readily comprehended by what precedes.

The circular operation is easily performed by carrying an incision with a tolerably long knife through the integument about three inches and a half below the point where the limb is to be removed. The skin being carefully raised for two inches from the aponeurosis, along with a thick layer of cellulo-fatty matter, the muscles are divided straight down to the bone, from which they are next separated for about eighteen lines, when the bone is sawed off in the usual manner, the soft structures being carefully protected with a retractor. Some surgeons prefer, after the skin has been reflected for a short distance, to cut, first, through the superficial layer of muscles, and then through the deep, somewhat higher up, so as to give the parts a hollow, excavated appearance, the apex of which is represented by the extremity of the femur. I have myself no fancy for such a procedure, although there is no doubt that it may occasionally leave a good, serviceable stump. The edges of the wound, in either case, should be brought together vertically, in order to facilitate drainage,

and the limb should be well bandaged from above downwards to prevent spasm and retraction of the muscles.

The late Professor Davidge, of Baltimore, performed amputation of the thigh with two flaps, by making an incision on each side through the integument, so as to encircle the limb, with the exception of about an inch and a third in the centre, above and below. The two cuts were then connected at each of these points by a V-shaped incision, the apex of which extended upwards a distance of at least three inches from the horizontal cuts. The cutaneous flaps were reflected back until they equalled in length a little more than the semidiameter of the limb, when the muscles were divided circularly down to the bone, which was next separated from its attachments for about eighteen lines, and sawn off as in the common amputation. This operation is not only neater than the ordinary one, but, what is of no little moment, it prevents puckering of the integument at the angles of the wound, and at the same time greatly facilitates drainage.

Amputation of the thigh by the rectangular method of Mr. Teale is described at p. 526 of the first volume, and, therefore, does not require any special notice here.

Very valuable statistics of amputation of the thigh in its continuity, after gunshot injuries, were published by Dr. S. W. Gross, in the *American Journal of the Medical Sciences* for October, 1867. Of 4123 cases therein given, 977 were successful and 3146 fatal, thus affording a ratio of mortality of 76.30 per cent. He ascertained the period at which the operation was performed in 1448 instances, of which 695 were primary, with 381 deaths, the mortality being 54.82 per cent., and 753 secondary, with 572 deaths, the mortality being 75.96, or 21.14 per cent. greater than that of early amputation. In the Franco-Sardinian army of Italy, in 1859, and in the French and British forces in the Crimea, removal of the limb was effected in its lower third in 236 cases, with 130, or 55.08 per cent. of deaths; in its middle third 268 times, with 175 deaths, or a mortality of 65.26 per cent.; and in its upper third in 225 cases, of which 177, or 78.66 per cent., died. The results of conservative treatment in gunshot fractures of the thigh, in the Franco-Sardinian army, the French army in the Crimea, and the United States army, as given by the same authority, were more encouraging than those of amputation. Thus, of 295 cases in the lower third, 150, or 50.84 per cent., were fatal; in the middle third, of 327 cases, 181, or 52.29 per cent., were fatal; and in the upper third, of 445 cases, 306, or 68.76 per cent., were fatal. If these results be compared with those of amputation in the different thirds of the thigh, they will be found to be very decidedly in favor of the former. The entire number of cases of gunshot fractures of the thigh treated by expectancy, collected by Dr. Gross, was 1450, of which 923, or 63.65 per cent., proved fatal; thus affording a better result than that of removal of the limb by 12.65 per cent., and of excision of the femur by 23.58 per cent.

Much of this frightful mortality is, doubtless, justly attributable to the excessive shock sustained by the crushing effects of the injury necessitating the amputation, to the violence inflicted upon the patients during their transportation from the field of battle, and to the influence of the vitiated air of military hospitals; all tending to produce a state of exhaustion incompatible with repair, and promotive of the occurrence of erysipelas, osteophlebitis, pyemia, and typhoid fever.

AMPUTATION AT THE HIP-JOINT.

To no operation that can be performed on the human body is the oft-repeated maxim, "*Ad extremos morbos extrema remedia*," more justly applicable than to amputation at the hip-joint. The operation may become necessary both on account of disease and accident; but it is of so formidable a nature and so fraught with danger, that it should never be undertaken unless the patient has no other chance of escape. The great risk which attends it is chiefly due to the loss of blood, suppuration, erysipelas, and pyemia. The hemorrhage, however, will not, in any case, be likely to be profuse, if proper care be taken to compress the arteries during the formation of the flaps, and if the operation be performed, as it always should be, in twenty-five or thirty seconds, good and trustworthy assistants being at hand to anticipate the surgeon's wishes and facilitate his movements. Under highly favorable circumstances, much of the enormous wound may unite by the first intention; but, in general, more or less suppuration takes place, and in some instances the discharge is so copious as to lead to fatal exhaustion. The greatest danger of all, however, is

the occurrence of pyemia, or secondary abscess, especially in amputation at the hip-joint in consequence of injury, as a compound fracture or a gunshot wound. The shock of the operation must formerly have been very violent, and often of itself sufficient to cause death within a short time after its performance: now, however, that we can avail ourselves of the use of anæsthetic agents, no special risk is to be apprehended from that source.

This operation, for a long time regarded as impracticable, and until lately alternately praised and condemned, was first performed, in 1748, by La Croix, of Orleans, upon a boy, fourteen years of age, the subject of gangrene of the lower extremities from the use of ergot. The operation, if so it deserves to be called, consisted chiefly in separating the devitalized structures with a pair of scissors, and proved fatal on the eleventh day. The first successful case upon record is that of Perrault, of St. Maure, in 1773. It was one of traumatic gangrene, the particulars of which are fully described by Sabatier in his *Médecine Opératoire*. In 1774 Kerr, of Northampton, performed the operation upon a girl, twelve years of age, on account of coxalgia complicated with lumbar abscess. Death occurred on the eighteenth day, apparently from tubercular disease of the lungs. These cases were followed, near the close of the century, by those of Blandin, Perret, and Larrey, of the French army. The first successful example by a British surgeon occurred in 1812, in the hands of Mr. Brownrigg, in a soldier whose thigh bone had been broken at its upper extremity by a gunshot nearly twelve months previously. In this country amputation at the hip-joint was first done by Dr. Walter Brashear, of Kentucky, in 1806. The patient, a lad, seventeen years of age, the subject of a bad fracture of the femur, complicated with severe contusion and extensive suppuration, made an excellent recovery, and survived the operation many years. The next case, also a successful one, in the United States, was that of Dr. Mott, in 1824.

Amputation at the hip-joint may be performed in a great variety of ways, with two of which in particular the surgeon should be familiar, as the circumstances of the case may leave him no opportunity for choice. These are the lateral and the antero-posterior flap methods, of which the first, as a general rule, deserves a decided preference, from the fact that it admits of more ready drainage during the healing of the stump.

In the lateral amputation, the external incisions should always be made first, although this is not so important when there are skilful assistants, of whom there should be at least four; one for administering chloroform, two for retracting the flaps and compressing the arteries, and one for holding the limb. If these matters be properly attended to, the operation is a comparatively easy one, and may often be executed in an almost incredibly short time, and with the loss of hardly a few ounces of blood. The buttock being brought well over the edge of the table, the thigh pretty widely separated and everted, and the femoral artery compressed over the brim of the pelvis, the knife, which should be upwards of a foot in length, is entered, supposing the operation is performed on the left limb, immediately below the tuberosity of the ischium, and made to issue at a point midway between the anterior superior spinous process of the ilium and the great trochanter. The external flap is now formed by cutting downwards and outwards, in close contact with the bone, for at least four inches, especially if the subject be at all muscular. An assistant is ready to seize and retract the flap the moment it is fashioned, as well as to compress the orifices of the bleeding vessels. Reinserting the knife into the upper angle of the wound, it is rapidly pushed down, along the inner surface of the bone, so as to form a large flap in that direction, to compensate for the small one on the outside. The assistant having charge of the femoral artery in the groin now grasps the divided vessel, at the same time lifting up the flap. The next step of the operation is the disarticulation, which is readily effected by opening the upper and inner part of the joint, and then swiftly carrying the knife around the head of the bone, previously rendered prominent by depressing the knee. The arteries are now secured, first the femoral, and successively any other that may require the ligature, the assistants maintaining the compression until every vessel is tied.

The antero-posterior amputation at the hip-joint, delineated in fig. 850, is conducted upon the same general principles as the lateral, the only difference being the manner in which the flaps are made. Great care must also be taken to hold the scrotum out of the way. It will be most convenient to make the anterior flap first; this, when the operation is performed on the left side, is done by entering the

knife on the outside of the hip, midway between the anterior superior spinous process of the ilium and the great trochanter, carrying it across the neck of the femur, and pushing it out at the centre of the thigh, immediately below the pelvis. The flap, which should be about four inches in length, is then formed in the usual manner; the joint is opened at its upper and inner part, as in the preceding case; and, the disarticulation being effected, the posterior flap is fashioned by cutting along the back part of the bone.

Great stress is very properly laid by surgeons upon the prevention of hemorrhage in this amputation.

With this view not a few recommend, as a preliminary step, the ligation of the femoral artery, while the majority believe that compression of that vessel, as it passes over the pubic bone, will generally be quite sufficient. In a case of amputation at the hip-joint, by Professor Pancoast, at the Pennsylvania Hospital, in June, 1860, this object was very effectually attained by compression of the abdominal aorta by means of a tourniquet, encircling the body at the umbilicus. The patient, a man, thirty-eight years of age, bore the operation well under ether, breathing with perfect ease, and losing hardly any blood, the application of the instrument being rendered the more satisfactory by the previous evacuation of the bowels. He survived the operation, performed on account of a large encephaloid tumor of the upper part of the thigh, two years, when he died from a return of the disease.

In the case of a girl, nine years of age, whose thigh I removed at the hip-joint in January, 1862, at the Philadelphia Hospital, on account of injuries sustained by a burn fifteen months previously, the circulation of the limb was effectually controlled by the pressure of the thumbs upon the abdominal aorta and femoral artery. The operation, in which I was kindly aided by my colleagues, Drs. Agnew, Levis, and Kenderdine, was performed in less than twenty seconds, with a loss hardly of an ounce and a half of blood. The patient, although exceedingly anemic and exhausted at the time, recovered without an untoward symptom, but died of valvular disease of the heart five years and a half afterwards. The case is given at length in the *American Journal of the Medical Sciences* for January, 1864.

The most efficient tourniquet for compressing the aorta is that of Dupuytren, represented in fig. 851, and variously modified by modern surgeons. It is easy of application, and the pressure may be so regulated as to answer the purpose most perfectly. The pad should be screwed down on a level with the umbilicus, a little to the left of the middle line, otherwise there will be danger of interfering with the circulation of the vena cava. The bowels should be thoroughly evacuated the night before the operation, and every possible care taken not to injure any of the abdominal viscera. The value of this mode of compression has been tested in numerous instances; and in the remarkable case related by Mr. J. Sampson Gamgee, of Birmingham, it was so effectual that, although the limb was so enormously enlarged as to weigh more than the whole of the rest of the body, yet hardly any blood was lost.

The appearances of the stump and the line of the cicatrice, in the antero-posterior operation, are well displayed in the annexed sketch, fig. 852, from a photograph kindly sent to me by Professor J. F. May, of Washington City. His patient, a man forty years of age, had been laboring under caries of the head, neck, and shaft of the thigh-bone, attended with great enlargement of the limb. The operation was performed within thirty seconds, with a loss of blood hardly amounting to eight

Fig. 850.



Amputation at the Hip-joint.

Fig. 851.



Abdominal Tourniquet.

ounces. A rapid and complete recovery followed. was taken nearly two years and a half after the op

Fig. 852.



Stump after Amputation at the H

case, referred to above, is exhibited at fig. 853. of a year after the operation. The flaps, made w

Fig. 853.



Amputation at the Hip-joint.

One of the great troubles, as well as dangers, after large persons, is the difficulty of keeping the surfaces of the flaps in contact with one another by any mode of dressing, however tight. To meet this contingency, and thus promote union, it is with much advantage, in a case under my charge, to use needles, passed through the flaps at different points, as in the common harelip suture. The operation was comparatively slight, and the recovery rapid.

During the after-treatment incessant vigilance is required for cleanliness and the use of disinfectants, as carbolic acid, or ganates, weak solutions of which should be freely applied from three to six times in the four-and-twenty hours. The stump must be most carefully guarded against elevation; the sutures must not be too soon removed; and the flaps must be applied with a certain degree of tightness in the opposed surfaces of the flaps. A small tent is applied in the inferior angle of the wound at the first dressing,

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intention is not to be expected under any circumstance after so formidable an operation.

The statistics of amputations of the hip-joint abundantly show that the results are, as a general rule, much more favorable when the operation is performed for the removal of disease than for the relief of accident; depending, unquestionably, upon the fact that, in the former case, the system is more enured to suffering, and, consequently, more tolerant of the effects of the operation, while, in the other, the change is too sudden and severe to enable it to bear up under its exhausting influence.

Mr. Erichsen, availing himself of the labors of Dr. Stephen Smith, and also of those of other writers, has given the results of 126 cases of this operation, of which 76 proved fatal. Of 47 cases in which it was performed for injuries, 35 died. Professor Blackman, in 1857, published a statement of 142 cases, including 1 operated upon by himself, of which 45 were successful and 97 fatal. According to Dr. Macleod, of the ten cases that occurred in the Crimea, not one recovered. A successful instance of amputation of the hip-joint was reported not long ago, by Dr. J. M. Warren, as the first of the kind that had ever taken place at Boston. It was performed on account of osteo-sarcoma of the femur, in a lad sixteen years of age.

Dr. G. A. Otis, who has collected all the cases of amputation at the hip-joint on account of gunshot injury, finds that, of 180, in which the result is known, 18 got well, and 162 died, the mortality being thus 90 per cent.: 76 operations were primary, with 1 recovery—that of Dr. Edward Shippen, of this city; 20 were secondary, with 7 cures; 76 were intermediary, with 70 deaths, and 8 were reamputations, with 4 cures. From these statistics the great advantage of deferring exarticulation is sufficiently obvious, since secondary operations afford rather more than one recovery in every three cases, whereas primary ones show a mortality of 98.68 per cent.

All experience shows that amputation at this joint, if performed immediately after a severe injury, whether gunshot, compound fracture, compound dislocation, or wound of any kind, proves almost invariably fatal. Hence the rule is always to postpone the operation to the latest possible period; certainly, if practicable, until suppuration has taken place, and the system has had time to become enured to its new condition. In compound fractures of the thigh, involving the head or neck of that bone and the integrity of the femoral vessels, the case, of course, does not admit of much, if any, delay, and the patient must, therefore, run his chance. If the vessels be intact, resection of the upper part of the femur should take the place of ablation of the limb at the joint. If the soft parts are extensively injured and the bone violently shattered, but its head remain sound, the most judicious practice is to amputate the limb at or near the trochanters, leaving the extremity of the bone in the acetabulum.

The happy results of consecutive amputation at the hip-joint in gunshot lesions are well exemplified in the practice of Dr. Roux, of Toulon, who performed the operation six times upon soldiers wounded during the war in Italy, with four recoveries and two deaths.

Amputation at the hip-joint, after previous amputation of the thigh in its continuity, or of the limb at the knee, was first performed by Mr. Guthrie in 1812, and has since been repeated in a number of instances. The first case in this country occurred in 1850, in the hands of Professor Van Buren, with a successful termination. The principal American operators have been Mott, Bradbury, Buck, Packard, Blackman, Morton, Whitcomb, Fauntleroy, and Otis. In 21 cases, analyzed by the latter, the amputation was performed in 12 for chronic osteomyelitis; in 6 for recurrent malignant disease, neuroma, or scrofulous degeneration; and in 3 for hemorrhage or gangrene. Of these cases 14, or 66 per cent., were successful. Of two intermediary operations of this kind, performed by Mr. Fayrer, one was successful, and the other was fatal.

A singular case of amputation at the hip-joint complicated by complete ankylosis has been reported by Professor Eve. After the flaps had been formed by the antero-posterior method, the bone was sawed at the trochanters, and the head removed with the chisel, gouge, and hammer. The patient, a man, thirty-six years of age, greatly exhausted by protracted suffering, died twenty-five hours after the operation.



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